

# PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH  
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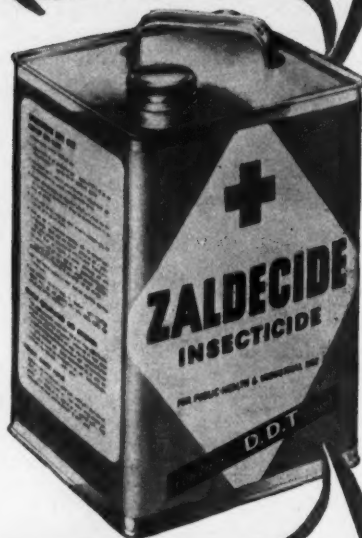
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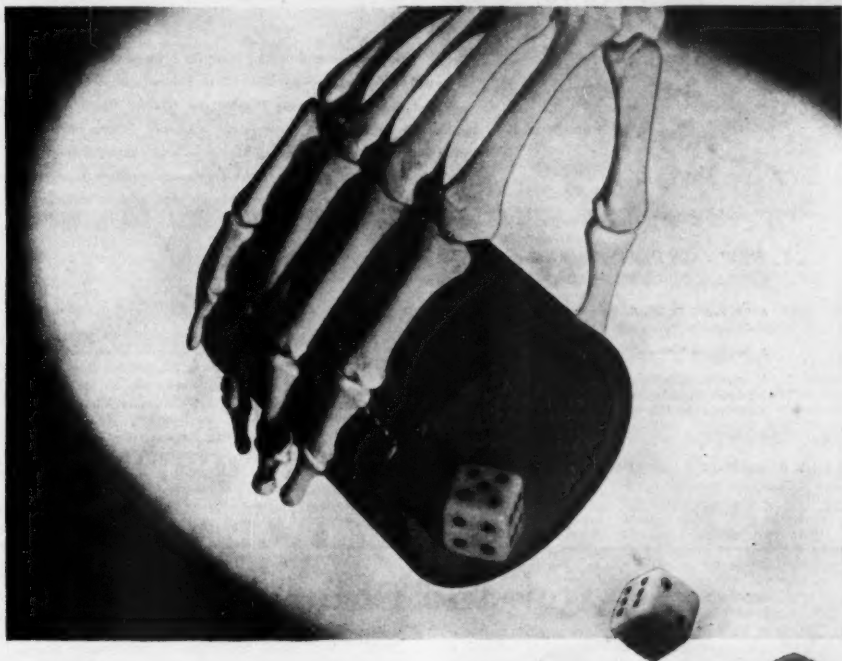
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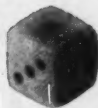
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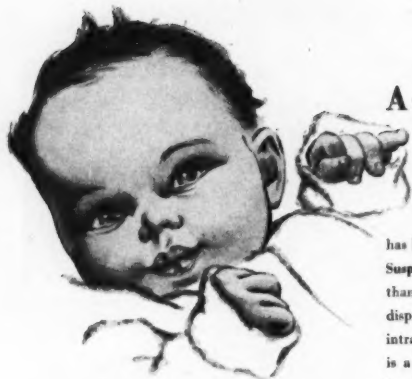
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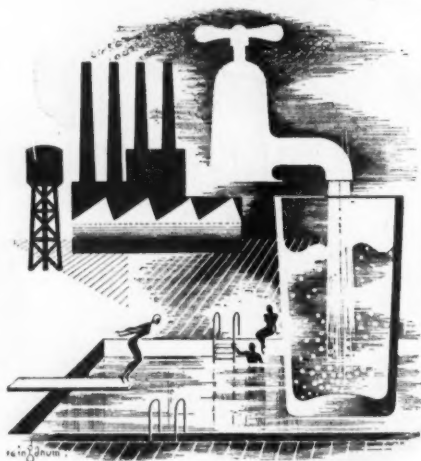
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### EDITORIAL

#### Cooperation in the National Health Service

*Post-mortem* examination of the present generation of Medical Officers of Health would almost certainly reveal the word "cooperation" written on their hearts. Ever since the Act of 1946 dropped statutory "iron curtains" between the general practitioner, consultant and hospitals, and preventive branches of medicine, the main endeavours of all men of goodwill have been to re-establish methods by which the three sections of the National Health Service can work together without friction or overlap. The Society of Medical Officers of Health has been assiduous, almost to the point of *ennui*, in pressing for exchange of information and for full and proper use to be made of the Public Health Service.

Progress has undoubtedly been made, but it was welcome news that the Central Health Services Council had appointed a special committee on cooperation in the National Health Service, whose membership included Sir Allen Daley, Dr. Frederick Hall and Prof. R. H. Parry to represent the public health side. The Society submitted a memorandum of evidence\* and its witnesses attended before the committee. In its annual report for 1951, the Central Health Services Council states that it adopted its committee's report, with one modification designed to allow greater flexibility of method, and that the Minister of Health had agreed to the separate publication of the co-operation report† in full; its main recommendations have also been conveyed by circular to the three types of N.H.S. authorities concerned.

The Society, in its evidence, recommended that the existing methods of co-operation, mainly in the form of regional medical liaison committees at officer level, should be backed up by higher joint consultative bodies at member level which should try to agree policy and planning matters, with a view to their agreed findings, being implemented by the boards, executive councils and local health authorities which they represented. The C.H.S.C. Committee, however, has reached a different and perhaps better conclusion, which, as was pointed out in an editorial‡ in the *Medical Officer* of May 17th, may have the most far-reaching results. Having studied the question of the best

geographical units in which local liaison committees might operate, the C.H.S.C. Committee reached the following conclusions:—

"(a) The County Borough, or other large town, should be in most areas the centre on which a committee is based.

"(b) Since the county population almost always makes extensive use of hospital services situated within the County Borough, both the County and County Borough and two Executive Councils are interested in the same problems and should be represented on the one committee.

"(c) A combination of Hospital Management Committee catchment areas or of areas of County Council divisional health areas with the County Boroughs they adjoin will usually prove the most satisfactory arrangement. But wherever possible a local health authority boundary should be used. (This will only be a County Borough boundary in the larger cities.)

"We suggest that the areas to be defined should be called local health service areas and that the committees should be called joint health consultative committees."

The Committee later states that much of the work of the committees would be done by officers already concerned in liaison arrangements and that the administrative expenses should be small.

Making all allowances for doubts about the value of yet another committee, we believe that these recommendations are imbued with common sense and realism and that their successful operation might revolutionise the whole meaning of the National Health Service. The *Medical Officer* editorial referred to above in fact foresees a statutory future for these joint health consultative committees by a typical British development. We hope that the Regional Boards will give early acceptance to the Minister's recommendation in Circular R.H.S. (52)42 to call conferences with all concerned for the setting up of the joint committees.

Many other things in the cooperation report will please Medical Officers of Health and strengthen their hands in getting agreement on common problems and dovetailing services for the benefit of the population.

#### Trend of Scarlet Fever in Recent Years

A brief study of the incidence of scarlet fever in the years since the Second World War has been published by the World Health Organisation.\* It shows that Europe, apart from the southern and south-western regions, still seems to be the continent where the incidence is highest. While scarlet fever has become much less serious since the beginning of the century, in many countries it has attacked a far greater number of people during recent years than in the period between the two world wars.

\* PUBLIC HEALTH (February, 1951). 64. 75-77.

† Report on Cooperation between Hospital, Local Authority and General Practitioner Services. Central Health Services Council. (Pp. 34.) H.M. Stationery Office. Price 1s. 6d. net.

‡ Changes in the Air. *Med. Officer*. (1952.) 87. 201.

\* *Epidem. vital Statist. Rep.* (1951). 4. 355.



In large sectors of Africa and Asia for which data are available, the number of cases of scarlet fever notified during the post-war years has been relatively insignificant. This has been true also in the Americas, except in Canada and, even more so, in the U.S.A. However, the figures in these last two countries are still comparatively small in relation to that in many countries of Europe.

Whereas from 1946 to 1949 and 1950 the annual number of cases notified in the U.S.A. decreased from 116,000 to 75,000 and then to 57,000, over the European continent as a whole it increased from 239,000 to 420,000, and then to about 520,000. Another illustration of this comparative trend is found in the number of cases recorded per 100,000 inhabitants: from 1946 to 1950 the annual number of cases notified in Canada and the U.S.A. did not exceed 76 and 83 per 100,000 inhabitants. In Europe, on the other hand, rates above 100 per 100,000 inhabitants were recorded in 10 countries in 1946, in nine in 1947, in 12 in 1948, and in 15 in 1949 and 1950. Sometimes there were more cases in a single European country than in the whole of the U.S.A.; for example, in 1950 there were 65,883 cases in England and Wales and 86,924 in the Federal Republic of Germany, as compared with only 56,851 in the U.S.A.

Significant outbreaks of scarlet fever occurred in a number of countries of Europe in recent years: in Bulgaria in 1946; in Ireland and Scotland in 1948; in Austria, Czechoslovakia, the Federal Republic of Germany, Hungary, Iceland, Northern Ireland, Poland, Sweden, and again in Ireland in 1949; in Berlin, Finland, Malta, Yugoslavia, and again in Austria, the Federal Republic of Germany, Poland, and Sweden in 1950; and in Finland and Spain in 1951.

The mortality caused by scarlet fever has shown a considerable decrease. In the U.S.A., between 1944 and 1948, the number of deaths dropped from 422 to 68 annually, corresponding to a case fatality-rate of only 0.22% and 0.0% respectively; these figures are in contrast with those for 1936, 1937 and 1938, when there were 2,493, 1,824 and 1,206 deaths, i.e., a case fatality-rate of 1.0%, 0.8% and 0.6% respectively. In Yugoslavia, where a particularly high morbidity-rate was recorded for 1950 (18,581 cases), mortality reached a rate lower than ever before: 37 deaths; this is in striking contrast with the rate for 1928, when there were 3,371 deaths for the 23,078 cases recorded. Only eight deaths from scarlet fever were recorded in Turkey in 1950, as compared with 400 in 1929 for an approximately equal number of cases notified. Australia, too, provides an illustration of the low death-rate from scarlet fever: from 1943 to 1948 the total number of deaths was 112 for the 59,098 cases notified.

### The Birthday Honours

The Queen's first Birthday Honours List contained generous royal recognition of the medical profession and of others associated with the national health. Public health and preventive medicine seem to be destined in this respect to hide their light under a bushel, but we were particularly glad to see that the rank of officer in the Order of the British Empire was conferred upon Dr. George Chesney for services as Medical Officer of Health for the Borough of Poole. The public health service would wish to congratulate also Mr. J. M. K. Hawton, Secretary of the Ministry of Health, upon the conferment on him of the K.C.B., and Dr. Charles Wilcocks, Director of the Bureau of Hygiene and Tropical Medicine and Editor of the invaluable *Bulletin of Hygiene*, upon his C.M.G.

*Programme in Edinburgh, July 18th and 19th.*—The Council will meet in the City Chambers, Edinburgh, on the morning of Friday, July 18th, and thereafter lunch with the Lord Provost and Magistrates. At 5 p.m. they will be the guests of the chairmen of the Scottish Regional Hospital Boards at the George Hotel. On Saturday, 19th, there will be a joint meeting with the Scottish Branch, followed by lunch at the Albyn Restaurant and a coach tour of the city in the afternoon. (See also page 172.)

## PREVENTIVE PSYCHIATRY\*

### With particular reference to Children

By W. WARREN, M.A., M.D., D.P.M.,  
Physician, Bethlem Royal Hospital and Maudsley Hospital;  
Medical Director, Brixton Child Guidance Unit

It is well known, and statistics need not be quoted here, that psychiatric illness is responsible for much human misery and economic waste. Apart from those people under treatment in mental hospitals, many more are partially crippled or rendered inefficient by neuroses or defects of personality; human relationships may be be-devilled in the home and outside; a considerable quota is added to crime, to broken homes, to the so-called "problem families" and to the ranks of the unemployed. The prevention of these would seem important.

Psychiatric problems cover a wide field. In this short talk some only can be surveyed, and by way of introduction I must briefly consider some general points. I am aware that brevity must lead to over-simplification and that may be considered unwise.

### Pathology and Aetiology of Psychiatric Syndromes

First, the pathology of most psychiatric ill-health differs from that of physical disease in certain fundamental respects; there are usually no organic changes to be found. How much easier to understand, for instance, is pneumonia, with our clear knowledge of its morbid pathology and the organisms responsible for it. Psychiatry, in contrast, deals with intangibles. Exceptions are of course found in such diseases as general paralysis of the insane or alcoholic dementia; and any psychiatric syndrome associated with organic disease of the central nervous or other systems invariably raises the same problems of pathology, and therefore of prevention as in physical medicine. Such need not concern us now, although the defects of personality or maladjustments that helped to lead to the acquirement of such a condition as alcoholic dementia are of direct psychiatric import.

Next, there is still considerable ignorance of the aetiology of that most important group of illnesses, the major psychoses. How is one to prevent schizophrenia or manic depressive psychosis in the present state of our knowledge? We know a little of their genetics, and the characteristics of people likely to develop them; it is another matter to take effective preventive measures. Again, we are equally helpless to prevent mental backwardness or defect. The study of their genetics has given us yet no clear guidance, and few effective steps to prevent them can be taken.

Turning to the neurotic illnesses or to the many maladjustments to life as we now need to live it; it is in these, with our knowledge of psychopathology, that attempts at prevention can be visualised. It is true that some of this group of troubles may only lead to some unhappiness and need no medical help. Who are wholly free from anxieties or never react to misfortunes? It is a relative matter; and when people show anxiety or depression, for instance, beyond that which is normal, or without adequate cause, then can they be said to be maladjusted or neurotic.

Apart from the question of hospital beds or psychiatric out-patients' departments, such people clutter-up doctors' surgeries, and are a trial and tribulation in every situation in life. However, I cannot now pursue the many paths of thought raised by these problems and I must confine myself to some aspects of their aetiology.

The causes of this hotchpot of troubles are many and complicated. Any person who breaks down or who develops neurotic symptoms does so as the result of a number of factors. The strains and stresses of life, great or small; frustrations, bereavements, economic and social difficulties and so on, may all play their part. Bodily health should not be forgotten. Nevertheless, people vary enormously in their reactions to the setbacks of life; most resist them

\* Address to the Metropolitan Branch, Society of M.O.H., London, February 8th, 1952.

with an almost surprising hardihood. Others develop abnormalities for little or no obvious reason. It seems that the bricks and mortar of which people's minds are made vary greatly in their quality.

Eysenck (1951), in a recent careful statistical study of the inheritance of neuroticism in twins, postulated that 80 per cent. of individual differences in a factor of neuroticism were due to heredity and only 20 per cent. to environment. This adds weight to the view that some are constitutionally more prone to neuroticism than others.

The life story of a neurotic patient, whatever may have preceded the crisis that led him to seek for help, reveals more often than not that neurotic symptoms or tendencies in one form or another dated back a long way, even into childhood. This is more easily seen in young patients in whom the events of childhood were not so long ago.

The beginnings of these troubles of adulthood started in early developmental years; so that whatever the quality of the patient's bricks and mortar, such could also have been well or badly built up into the structure of the adult mind. Even if there is a constitutional tendency towards neuroticism in anyone, yet it is possible that wise and trouble-free upbringing could have avoided the development of actual neurotic disorders.

The treatment of the adult neurotic is a long, tedious and often difficult task. Psychiatric "first aid" measures may help him on his way, but they will probably not fundamentally alter him. Any treatment that attempts to do so must include the consideration and even the painstaking analysis of his whole life, including the emotional troubles of childhood. A re-synthesis of the patient's emotional bearing must follow on a more healthy basis. Such a major operation is often impracticable, and how much better it would have been if the neurosis could have been prevented in the first place.

The abnormalities of personality are, by and large, more deep-seated and unchangeable. Each person is unique, all have some eccentricities, and we would be unattractive in our uniformity without them. However, when someone's oddities of character or quirks of behaviour bring distress to himself or others, or are anti-social, they may pass the bounds of normality.

Compared with the neurotic disorders, there may be a heavier constitutional loading—perhaps in some accompanied by an abnormal electroencephalogram. The well-known term "psychopathic personality" need not be described except to emphasise such a person's incorrigibility, whether he is anti-social or markedly eccentric in a less harmful way. It is probable that the development of some of these grosser personality disorders could not have been prevented; yet others seem to have deviated from the normal in early childhood, perhaps from emotional traumata or mishandling which scarred the still plastic personality structure. Recent writings of Spitz (1945) or Bowlby (1951) of the reactions of very young children a long time in hospital point to this and hint how they could have been avoided.

### The Value of Child Psychiatry

This brings me to my main topic of child psychiatry and my belief that some of its value to the community is that its practice may prevent further and more serious trouble later on. Perhaps it can be regarded as prophylactic in function, and that the title of this talk should have been "Prophylactic Psychiatry." The word "prevention" can then be reserved for such measures as can be taken to avoid psychiatric disturbances in childhood from starting at all, and this is an aspect that may most interest those working in public health.

I am conscious that I may appear to have made an unwarrantable assumption in stating that some of the psychiatric troubles of adulthood could have been avoided by appropriate attention in childhood. Lack of time prevents further discussion of the evidence for this, including psychopathological theory; but clinical experience of adults and children leads one to believe that the early years of life,

and the emotional influences that were exerted then for good or ill, were enormously important for future mental stability or instability. Those who are fortunate enough to have a happy and secure childhood can too easily take this for granted and not appreciate its positive significance for later life.

The Council of the Child Psychiatry Section of the Royal Medical Psychological Association in 1950 prepared a memorandum for the L.C.C. Committee on Juvenile Delinquency. It expresses succinctly their views on the basic needs of the child for normal social development. It states that normality in a child presupposes that he should have met firstly with a stable and secure affection in his home. In its relative or complete absence, he cannot develop normally and he is liable to a wide variety of neurotic disturbances. If he lacks affection in his early years, his capacity to return affection is atrophied, stunted or distorted. Hints of future disturbance of personality are to be seen in this statement, including perhaps a tendency to develop serious delinquent behaviour. Affection, in other words, is a primary biological need of the developing child.

It is tempting to enlarge on this theme, for a child guidance clinic constantly sees children with emotional disturbances, behaviour disorders or with serious delinquencies, who were unwanted in the first place, and overtly or covertly rejected by their parents. Such a child could not have met with secure affection. There is also the child whose mother died or deserted him in his early years and where no suitable mother substitute took her place; the child passed from billet to billet, or the infant who spent months in the emotionally sterile atmosphere of hospital. It does not matter that there may be many who had similar emotional traumata or deprivations who did not react in this disturbed way; those who do are a serious problem. To use a rather poor analogy, not all become ill who are exposed to some infecting organism.

Serious delinquencies have been mentioned, and to digress for a moment it is not suggested that deprivation of affection in early life, or other psychological mishaps, are solely responsible for them. Many sociological, moral or other factors are very important. Psychological factors add their quota; and they need investigation when suspected, or treatment when the offender is considered suitable for this.

The R.M.P.A. memorandum gives a second biological need of the normal child—stable but reasonable authority at home and in school. The latter can usually be taken for granted, but how often is this lacking at home? There are parents who are inconsistent in their handling of the child, who disagree between themselves over it; who are indulgent or slack on the one hand, or who are over-strict and punitive on the other; parents who are insecure, over-anxious or over-solicitous in their attitude; who fuss or nag the child, or who are bed-tempered. Is it surprising that the child, who needs to be secure, and who should sense how far he can go before reproof, should react with anxiety or bad behaviour?

The third requirement of the normal child or youth, stressed by the R.M.P.A. memorandum, is stimuli and outlets appropriate to maturing need for physical activity, to his imagination and creative ability and to his intellectual capacity. They are denied by overcrowded homes, lack of play facilities, faulty educational methods, failure to provide socially acceptable outlets for the instincts of youth and by ignorance and lack of understanding in adults. Most of these are well known, and one can take for granted to-night the need for good houses, with space for play, for adequately staffed nurseries, nursery schools and schools; the needs in youth for social activity and education in all its aspects. They are being provided so far as our economy allows. The question of ignorance and lack of understanding or imagination in parents or others can be deferred for the moment.

This memorandum stressed the needs of the normally endowed child. It did not describe the needs of those with

various weaknesses in their endowment. The problem of mental backwardness is, on the whole, outside the scope of this talk, although still not always spotted. Still less are such things as specific reading disabilities always realised. With increased diagnostic facilities, more help can be given to such children, with the avoidance of emotional upsets arising from their educational difficulties. There are others—more rare—with various abnormalities of the C.N.S.; hyperkinetic children or those with various dysrhythmias to be seen in the electroencephalogram. Finally, there are many with bodily ailments, including enuresis or asthma, likely to have psychiatric causation or concomitants.

#### Child Guidance Clinics

The Child Guidance movement came about in the last 30 years to deal with children with these many problems; problems which can be such a difficulty to those who handle them at home or elsewhere, whether they arose from a faulty endowment, or from some lack in his basic needs, or both. The term "child guidance" is a cloak more acceptable perhaps to the public than the term "child psychiatry." The movement has evolved, and any Child Guidance Clinic now has fairly uniform methods of working, even if detail varies with the personalities and views of those in charge.

My remarks will have indicated the key people necessary to staff such a clinic. First, a psychiatrist who takes clinical responsibility for the patient—his assessment and diagnosis, his treatment and disposal. A psychologist, whose concern is the objective assessment of the intellectual endowment of the patient; but with specialist techniques, contributes, for instance, remedial teaching to overcome certain specific educational disabilities. A psychiatric social worker, whose concern is the environment of the patient, be it his material circumstances or help towards readjustment of parental or others' emotional attitudes. These three work as a team, focusing on the problem from their special viewpoints, each interdependent on the other.

A detailed account of the case material which finds its way to a clinic would be wearisome, but certain aspects of it should be stressed. I have already indicated to some extent the aetiology of these problem children, and the sort of troubles that invariably are found on investigation of their background. Some causes are obvious to any interested observer, others are far more subtle and only apparent after most careful investigation. No single factor causes the upset; it is as a rule a combination of a number of factors.

When a child becomes disturbed, the psychiatric symptoms he may show may be very varied; whether in the realms of disordered behaviour, more obviously nervous or both. Much will depend on the personality and make-up of the child who exhibits them and on the causative factors that led up to them. However, they differ fundamentally in their meaning from the symptoms arising from a physical complaint.

A child brought to a doctor with a complaint may have perhaps a running ear, an erythematous rash, or constant blinking. Examination of the running ear or the rash will lead to a diagnostic formulation and appropriate treatment. These symptoms do not, as a rule, involve the child's personality in the least; except in so far as the child may be away from school for weeks, the parents may be fussy, and the pain or discomfort cause the child to be disagreeable or difficult. (Kanner, 1935.)

The child with constant blinking is a different proposition, and here there must be considerable involvement of the child's personality. It is the same with the whole range of other symptoms which are the concern of the psychiatrist. To do justice to their diagnosis, a child and his personality need to be considered as a whole, as also those people in his environment—such as his parents—who are important to him. It is necessary to consider, "Who and what sort of a child is he and what are his circumstances?" Only with knowledge of these can a fuller understanding be reached. Many psychiatric symptoms are

seen slightly or fleetingly in the normal or relatively stable child. What boy or girl has not had a nightmare, perhaps been afraid of crackers, or lost its temper? However, when the child has become emotionally disturbed so as to need medical help, symptoms become exaggerated and increase until they give rise to notice and complaint by those in charge of them. The anxious and intelligent mother will be quicker over this than the duller and less solicitous mother. The child himself will rarely formulate a complaint, unlike the child in pain with earache. If emotional disturbances are slight, they may appear almost singly; with increasing trouble they become more marked and spread so that more appear. At first they may only be realised in the home, while those outside notice nothing; if more severe, they may also, for instance, be noticed at school and teachers may ask for the child to be treated. Of course, if the precipitating factors happen to be in the school, the symptoms may first appear there. Perhaps I may leave this with two illustrative case histories: first, of a mildly disturbed child and, second, a severely disturbed child.

#### Case 1

A girl of nine had since the age of five been crying out in her sleep two or three times a week; for the last three years she had repeatedly sleep-walked, come into her mother's bedroom and talked to her about going out to play or about her teacher. Further enquiries revealed that she knew she walked, but could not stop herself. She was a little faddy over food, and she had lately bitten her lip when concentrating. Emotionally, she was quiet, rather timid and sensitive, but on the whole happy. No other evidence of disturbance was found, and her previous history was normal. She was of average intelligence.

Investigation of the background revealed that the mother had a mitral stenosis, and had been sterilised after the birth of the last child. She had three other children, the patient being the eldest daughter. Mother, in spite of her ill-health, left the home each morning at 6 a.m. to work. The patient had considerable responsibility for her age, including getting the others their breakfast and off to school. A visit to the school revealed the patient's fear of being late, enhanced by a loud-voiced and overbearing headmaster, who was reputed to use the cane on latecomers—in fact, a kindly, raucous man. The sleep-walking had become a family tradition, and the patient gained a dubious notoriety for it.

Treatment was directed to the correction of these casual factors at home and at school; the sleep-walking promptly ceased and was no longer a focus of interest. Efforts were made to draw out and help the child's timidity and to lessen her burdens.

This is a good example of a child with the symptoms of a mild emotional disturbance, easily corrected by a little understanding. I venture to say they might have been treated by her family doctor with success.

#### Case 2

A boy of 11 who, in his mother's words: "He is extremely dirty in his habits, he wets and messes himself, however much we talk to him, coax him, and give him all sorts of things. His dad and I think it is due to masturbation which had gone on for a number of years. His father has spoken to him like an adult and told him all sorts of things. As he has got older he has got dirtier. I keep him in his own room; he did get out of bed and play with his brother, showed himself, so we separated him. I have to be after him every minute to make him wash. He was always loose in the bowels, and he wet the bed as a child. He has to wear a rubber pith. We find when we promise him things he eases up, but he goes back again. He has no pride in himself. It does harm him, I have to bath him, a boy of 11. When he goes to the lavatory he walks about and messes himself. It is getting me down. My nerves are dreadful, it makes me sick each time I undress him. It has upset our life, and we have not been out to the pictures for over five years in case he gets up to anything."

Direct questioning revealed he was messy with his food, he was clumsy, and got his clothes torn. His speech was slow and he muttered. His mother called him "dopey" as he would not listen. He usually had a "long face" and looked injured when rebuked. He was stubborn. He was, however, generous and gave his brother his sweets. He was over-sensitive and easily influenced, provocative and noisy.

Behind this gross disturbance, there had been a rejecting mother, a trained nurse, who cared nothing for her young



children, left them by day to work, was unfaithful to her husband, and finally deserted. The children were boarded out, and came back to a stepmother who developed a depressive breakdown. It was she who gave this account of the child. She was obviously doing her best. Father was a forceful and un-understanding statistician, quite hostile to the boy. The boy was admitted to hospital, improved considerably, but while efforts were being made to find a suitable place for him away from home, his father removed him.

The failure in this case lay in the fact that no change in attitude could be brought about in this father.

These two case histories indicate once more that attention need not be turned primarily to the child's symptoms, but more to him as a whole, to his personality and to his environment. Symptoms of emotional disturbance may have quickly arisen, but fortunately they can disappear again with equal facility, with right handling. The ease or difficulty of treatment is often dependent on what can be done to the causative factors. A full and living picture of the family and its circumstances needs to be built up with all the emotional cross currents to be found between its various members. A spot light needs to be turned on them and allowed to light up particularly mother and father. Often attention has to be directed to them rather than to the child, who may be reacting to their difficulties. It has to be remembered that their difficulties and attitudes, perhaps unhealthy and neurotic, grew in the first place out of their childhood circumstances; and so can each generation taint the next. It is no easy job to influence such parents; a little sage advice may not cut much ice; more adequate means are usually needed to bring about a necessary change of heart, and this requires an appreciation of the subtle psychological mechanisms at work in them. However, it is clear that each problem has to be fully and carefully assessed, and in the light of this assessment, the attack on it should be a total one, with the use of any method that is considered profitable, whether it be physical, psychological, psychiatric or social. One or other approach may be dominant according to the needs of the case. If the patient's material circumstances are found to be adequate, then attention to social factors may not play a big part. On the other hand, it is no use working, for instance, towards a mother's better understanding of and bringing-up of the patient if she has six other children and a drunken husband, living in three rooms, and with little money coming in. She would hardly have time or inclination for such luxuries, while the alleviation of her obvious stresses and worries would be urgent. In easier circumstances she might well bring up her children in a more satisfactory way without a breakdown.

Again, it is of little use to concentrate, perhaps, on remedial teaching towards solving a child's educational difficulties, and ignore the nagging of his ambitious parents, who hold him up to ridicule in front of his brighter and more successful younger sister. If time allowed, examples of the need for a wide approach could be multiplied.

Child psychiatry has been said to be prophylactic in its function. Apart from the immediate alleviation of the misery of the patient and those around him, it may help to free him to develop on more healthy lines towards maturity; to prevent perhaps later confirmed delinquent behaviour or the more ingrained neurotic patterns of adulthood. Its success or otherwise will mainly depend on what can be done to counteract those processes that caused the disturbance; and on the whole, the longer such help is delayed, the more difficult the task of the clinic.

It is a common experience, when a new clinic opens, for the most noisy and trouble-making children to arrive at its doors first, accompanied perhaps by quite an army of bed-wetters. The lay person is likely to assess psychiatrically ill children by their nuisance value; and if children's behaviour has become intolerable before referral, then it is likely that the disturbing factors are of long standing, so that the child presents a tough problem of treatment. Much worry and difficulty might have been avoided had they been sent earlier. Again, using the same yardstick for referral,

the depressed, timid, shy, anxious and inhibited children may be left even longer. They cause much less trouble to the authorities but they may be just as sick, and potential candidates for severe neurotic troubles later on.

Any Child Guidance Clinic is apt to acquire a long waiting list; the turnover of patients is slow, so that it is again the trouble makers who come first as urgent cases. The provision of an adequate number of clinics—an expensive business—would allow quieter or earlier problems to be dealt with. It is doubtful if the supply of patients would be exhausted in any area at present, and indeed the number of psychiatrically disturbed children in the population is probably larger than is suspected. I believe that when referring agents know that a waiting list is not too long, less obvious problems would be referred and a more tractable clientele would come. The better the facilities, the wider the net can be spread. This is fundamental and it is no use trying to attract patients in an early stage of psychiatric disturbance, unless they can be promptly dealt with.

One of the first tasks of a clinic is to get to know its neighbourhood, its referring agents, and in turn to be known by them. This is easier in a small community than in the vastness of London; but in London the problem can be solved by concentrating on an area within reasonable distance around the clinic. There are many preconceptions about child psychiatry, cynical doubts or occasionally exaggerated hopes. It seems that referring agencies should have a realistic knowledge of what can or cannot be done in such a clinic; and such would include general practitioners, school doctors, maternity and child welfare centres, Care Committees and, through them, the schools; courts and probation officers, youth club leaders and others. Similarly, the clinic would need to get to know agencies for helping in treatment and disposal of patients; for instance, the juvenile employment officer or the housing officer. The clinic staff should be ready to go out, if invited, and explain the functions of their clinic to those who come in contact with children in their work. It may oil the wheels of officialdom and ensure better treatment for patients.

### Prevention—General and Individual

Turning to the question of prevention, it can be considered under two broad headings: Measures affecting the general community; and measures, many of them educational, directed more to individual people.

Many steps under the former heading are already taken in public health work, or visualised when economic circumstances make them possible. The Education and Mental Deficiency Acts or the Adoption laws are obvious examples; the Curtis Report and its implementation is another landmark. The provision or improvement of housing, schools, nurseries, youth clubs and so on are all familiar. Anything that helps to raise social and economic conditions, spiritual values and the level of education, promotes mental health. In a short talk, it does not seem wise to try to survey these matters. They raise controversial questions, and are part and parcel of the general betterment of social conditions. Many are not the direct concern of psychiatrists, some of whom have perhaps properly been accused of being too vocal on how to set the world to rights. Psychiatrists or psychologists are in a position, however, to contribute opinions of value when some measures concerning children or others are planned.

Before discussing measures designed to influence individual people, it seems essential to try to clarify a fundamental aspect of psychiatric practice over which there is much confusion. When a doctor is consulted because of physical illness, he is presumably approached as someone in authority by the patient, who automatically puts himself into a submissive and dependent rôle. The doctor is in a position to give advice, which is normally accepted if there is mutual trust and confidence, e.g., to go into hospital and have an appendix removed. A psychiatrist also may take the same rôle, telling the patient he is depressed perhaps, and that he had better have a course of electric convulsion treatment. If, however, a psychiatrist investigates a patient

—adult or child—and finds him suffering from a neurotic illness or emotional maladjustment, then he must take a different rôle, and if psychological treatment is to be given, he is wise as a rule not to offer direct authoritative advice apart from reassurance. Such advice can be more appropriately sought by anyone in difficulties from friends, a lawyer or a priest; a psychiatrist, who hopes perhaps radically to change the patient for the better, has to use a more subtle technique.

The case of the severely disturbed child revealed a depressed stepmother, helpless and highly anxious over a first-class problem in her stepson; herself thoroughly involved emotionally in his troubles, guilty because she had failed to cope with him. His father, on the other hand, rigid and prejudiced, rejecting the child. In such a case, much careful work has to be done first to get a true assessment of the situation and then to try to get these people to alter their attitude to the child. It is no use telling them their attitude is wrong and advising them to change it; it would be likely to make the stepmother more guilty and anxious, and the father probably would not accept it. They need most tactful handling and careful preparation. There is no need to go into the techniques used in such work, nor into psychopathological theories; but with the help of a good relationship between therapist and parent, it would probably be necessary for such a mother to be able to express her anxieties and unhappiness about the child, to come to see the whole situation in a clearer light, to understand herself better and thus to get new confidence to tackle her awkward stepchild. Father would need to become less prejudiced, to realise why he rejects the child, and so on. The child, of course, would need treatment with techniques suitable for his age, to try to get him over his disturbed behaviour. If all this could be done, there would be a chance of a smoother life for them all.

Sometimes in such families, the more one learns of them, the deeper the problems are found to go; perhaps difficulties and dissatisfactions in the marital relationship, or emotional difficulties earlier in their lives, all relevant to the present impasse. One may try to sort them out or one may decide to leave well alone; but at least, one can be aware that what may seem sensible advice may not be acceptable, or misunderstood because of prejudices and emotionally determined attitudes.

These facts are applicable also to educative measures, which might have seemed at first sight an important step towards preventing psychiatric disturbance in the young; for instance, education of parents on normal development, the handling of children, what to do and what not to do. Traditional ideas on upbringing have been attacked, but little has been put forward to replace them. A certain amount of such education can be given with advantage, but its usefulness has definite limits. If a parent is emotionally stable, then knowledge of this sort is helpful; but if there is emotional instability, over-anxiety and insecurity, it is these probably long-standing factors that will cause difficulty rather than ignorance. Mothers, stuffed with psychological reading, which does not work when they try to put it into practice, are not uncommonly seen. Security and happiness in the emotional relationship between parents and children are the basis of successful upbringing; if they are present, the methods used by parents do not matter so much and indeed cultural habits over these vary widely with equally successful results. On the other hand, some enthusiasts have, I believe, tried to bring up their children according to strictly psychoanalytic principles; this was not always a panacea for the reasons suggested.

Experience of lecturing a "Parent-Teachers' Association," for example, has shown how much anxiety can be raised in parents over their children. The greatest care in the technique of lecturing to such a gathering is needed to reassure and to instil confidence, or more harm than good can be done. The anxious ones can easily be spotted, or those who reject out of hand the information given, for reasons of their own; the lecturer may easily find

himself buttonholed afterwards to try to settle the doubts of some mother. Some of these parents may even already be in need of treatment, and lectures or reading psychological books beforehand will not have prevented the development of difficulties and the need for personal help.

It seems important to repeat the fundamental fact that the seeds of trouble were perhaps sown far back in the parents' own childhood. Parents are successful not only by exercising their intellects; far more depends on their emotional attitudes, which are little governed by conscious reasoning. The canker of neuroticism may descend from one generation to another in this way, apart from the possible influence of hereditary factors. Can its malign effect be warded off? When planning educative measures, this considerable difficulty needs to be kept in mind.

A lecture from a psychiatrist can only give information which may or may not be acceptable to the listeners. Quite a lot will depend on his personality and his ability to handle his audience, whether it be parents or others. Suitable groups can be found in townswomen's guilds, parent/teachers' associations, or perhaps in maternity and child welfare centres. Such groups are fairly alive these days to psychology and wish to hear of it. It has been suggested, however, that rather than a didactic lecture, it is more effective for a group of mothers to be encouraged to talk of and share their experiences of bringing up children with each other. The lecturer acts as a chairman and keeps control; anxieties may better be alleviated by this and more be achieved. Confidence and interest would, of course, have to be gained and held perhaps over a number of sessions.

A closer link between the staffs of a maternity and child welfare centre and its local child guidance clinic may bring benefit in other ways. It is in the maternity and child welfare centre that the earliest difficulties of bringing up children are likely to be met, and at a time when they are most likely to be amenable to help, whether preventive or curative. How often are the staffs of these centres alive to such things? How much could be achieved would be a matter of experiment, and all would depend on inter-personal relationships between the staff of one centre and another. It could, however, be a fruitful field for research. To go back further in the child's life would bring one to the maternity ward, where research, for instance, into the psychiatric aspects of breast feeding (Middlemore, 1941) has been done. Finally, the researcher could apply his techniques to the clientele of the Marriage Guidance Bureau, where the difficulties of prospective parents are to be seen. One suspects, however, that in all these places, one would bump up against different stages of the same fundamental legacy of neuroticism, being handed on from one generation to the next. To stop this process is not an easy matter, and adequate provision for the treatment of the emotional disturbances of the adult populace is necessary. We have, indeed, come round full circle on this question of prevention.

Another sphere altogether, in which the psychiatrist and educational psychologist are inevitably interested, is in the schools. Teachers, trained in a different discipline, have a knowledge of children which the psychiatrist cannot have; it is not the latter's job to attempt to teach them their business. However, whatever troubles may have occurred in the pre-school years, these and new troubles can still be picked out or even prevented in the school years.

Recent experience of working in close association with teachers of psychiatrically ill children, in the school provided by the L.C.C. in the Bethlem and Maudsley Hospital, has shown how much each can help the other to the benefit of the children concerned. One can begin to visualise how such mutual help can be extended elsewhere. Time does not allow further discourse on this, but the problem, for instance, of the care and education of maladjusted children both in ordinary schools, or when sent to special schools, needs urgent study.

There are other matters of common concern, and the question of sex education in schools is an example. A

psychiatrist agrees that simple biological knowledge is necessary and is rightly given, but he would not expect the recipients thus wholly to be freed from sex difficulties. He believes that such intimate matters as sexual development and its understanding, are greatly influenced by the unspoken attitudes of the family and the interrelationships, happy or otherwise, in that family. Deep affection of parents for each other and for the child on the one hand, or marital rows on the other, are fundamentally far more important in determining the child's future sexual adjustment or maladjustment. One would be interested to know what are the teachers' views.

Mental health or ill-health may depend on the most delicate issues, difficult to verbalise in a short talk. However, a clinician, caught up in the treatment of patients, may not see the wood for the trees, and he may not be sufficiently alive to the promotion of health. This talk, necessarily confined to a few issues, may serve as an introduction to discussion, and suggestions for the advancement of positive mental health are welcome from those more knowledgeable of preventive work.

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### STATISTICAL AND OTHER ARGUMENTS FOR AND AGAINST CANCER EDUCATION

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During the last few years there has been an increasing interest in the education of the public concerning cancer. This is particularly true of the U.S.A. and Canada, and to a lesser extent in Norway and other European countries. Even in this country some interest has been noticeable, and evidence of this is seen in a leading article in *The Times* of May 4th, 1951.

The argument in favour of such education rests on the undoubted fact that treatment is more often successful in patients in whom the growth is found to be in an "early stage" as judged by clinical examination, compared with those in whom the disease is more advanced. It will be seen later that "early stage" and "early diagnosis" are not always synonymous, i.e., they do not always run parallel.

As examples of the above-mentioned fact concerning the prognosis in the "early stages" of the disease may be quoted the statistics of the five-year survival rate without symptoms or signs of the disease, in cancer of the cervix uteri and cancer of the breast. (Table I.)

TABLE I  
 CANCER OF THE CERVIX UTERI

	Patients treated	Five-year survival	Percentage	Percentage of cases treated in each stage
Stage I	5,635	3,439	61.0	13.7
Stage II	14,591	5,926	40.6	35.6
Stage III	15,061	3,317	22.0	36.7
Stage IV	5,749	375	6.5	14.0
Unclassified	10	0	0	0
	41,046	13,057	31.8	100.0

These figures are quoted from Vol. VI of the International Annual Report on results of Radiotherapy in Carcinoma of the Cervix Uteri, 1951. It will be noted how small a proportion of patients are treated in Stage I.

In his report on "Cancer Registration in England and Wales" (H.M. Stationery Office, 1950), Dr. Percy Stocks sets out (Table V) "the median number of months interval between the earliest symptoms and the start of treatment for cancer of various sites" which were recorded in 1945 and 1946. These figures are taken from various hospitals. The average "delay period" from 26 hospitals for cancer of the cervix is 5.7 months. From such figures it is argued that if all cases could be treated when the disease is in a clinically "early stage" thousands of lives would be saved.

**Breast Cancer.** In a series of 2,129 records of cancer of the female breast collected from various hospitals in the County of London by the British Empire Cancer Campaign and analysed by Col. W. L. Harneth, the figures in Table II may be quoted.

TABLE II  
 CANCER OF THE BREAST

	Number	Survived	Per cent.
		Five years or more	
Stage I	485	274	56.5
Stage II	467	164	35.1
Stage IIIA	224	88	39.3
Stage IIIB	538	105	19.5
Stage IV	362	8	2.2
Not staged	53	25	47.2
Total	2,129	664	31.2

In Stocks' report, quoted above, the average "delay period" for 30 hospitals is six months, and in the B.E.C.C. series 19% of patients waited more than a year.

In Massachusetts an intensive educational campaign has been carried on since 1935, when the "delay period" for all types of cancer, due to the patients, was 6.2 months, but by 1940 it had been reduced to 4.6 and by 1948 it was 3.9 months.

So far the arguments in favour of cancer education seem to be overwhelming.

What, then, are the arguments used by the opponents of cancer education, of whom there seem to be a number in the medical profession but no evidence of any among the laity? Perhaps the argument most commonly used is that such education will increase fear and apprehension.

At present it is impossible to prove by figures this question whether there would be an increase of fear and apprehension, but sample surveys carried out from time to time may produce some evidence in years to come.

To those of us who have had the experience of lecturing about cancer to the laity over a period of many years, the possibility of doing harm is unthinkable. From time to time I have handed round copies of a questionnaire (to be answered by a simple X) asking if the lecture has increased apprehension or if it has diminished it, and whether in the opinion of the audience such lectures should be continued. In practically 100% a favourable answer has been received.

There is abundant evidence that there is a psychological condition due to cancer which is almost universal. It shows itself in many ways, e.g., in obituary notices cancer is referred to as a "long illness bravely borne." Again, people seldom say Mr. X has cancer, but refer to it as "something serious." The same person will not hesitate to say "I am afraid poor old Y. is dying of heart disease," and yet many more people do die of heart disease than of cancer.

It must be admitted that, in spite of the somewhat terrifying cancer educational literature used by the Americans, they have succeeded in getting rid to a large extent of the "taboo" on cancer.

Although the primary object of cancer education is to diminish the mortality due to the disease, a secondary object almost as important is to get rid of cancer apprehension. To most women, when they feel a pain in the breast, the first secret thought that occurs to them is "Can this be cancer?" and on many occasions I have been thanked after a lecture for removing this idea that cancer of the breast starts with pain. There is no doubt that from a psychological point of view, properly directed cancer education can do nothing but good.

A second objection raised is that education will fill the *surgeries and out-patients' departments* with patients who have no physical ailment. Although proper education does guard against this, actual figures can only be obtained when "a critical experiment" has been started. It certainly will not increase the number of beds occupied in hospital because practically every case of cancer is admitted at some time during the course of the disease. If the case is diagnosed in an "early stage" the stay in hospital will be much shorter than if the disease is already in an advanced stage.

The next objection to be discussed is far more important and must be considered at some length.

The contention is put forward by some people that even if the "delay figure" was cut down from an average of six months to that of one to two months, the number of patients treated in the "earlier stage" of the disease would not be materially increased, and therefore the mortality would not decline. This argument is based on the fact that different growths metastasise at different stages in their development, and some people go so far as to maintain that if a tumour has the power to metastasise it will do so before the "primary" gives rise to symptoms.

It is well known that some cancers metastasise very early in the course of the disease even while the "primary" is very small. As an example might be quoted melanoma of the skin, while at the other end of the scale are rodent ulcers which rarely, if ever, metastasise.

Every surgeon has met with cases of breast cancer in which the primary is very small at the time of treatment, but in which even after extensive operation the patient dies of metastases within a few months. Again, there are a few cases of true breast cancer in which the growth has been present for several years, and after operation the patient has lived for many more years.

Dr. N. E. McKinnon has written extensively on this question, chiefly in the *Canadian Journal of Public Health*, during 1949, 1950, 1951 and 1952. It is not easy to summarise all that he has written, but it would seem that he divides all cancer growths into (a) those which metastasise at an early period in the course of the disease and before symptoms occur; (b) those which do not metastasise but if untreated will eventually kill the patient by extension of the local growth. He contends that type (a) is incurable and that only type (b) are cured. He bases his argument (*Canadian Journal of Public Health*, June, 1950) on the fact that the mortality due to breast cancer in all the provinces in Canada has remained fairly constant irrespective of whether the province has gone in for cancer education or not. He does not, however, give any figure to prove that the "delay figure" has gone down in the province where education has been adopted. Much of the education consists in trying to persuade patients without symptoms to have an annual overhaul, but it is questionable whether that will make a great difference to the mortality if the people are ignorant of the symptoms. The question of how education is carried out is all important. At first sight he seems to be on firmer ground when he says that the mortality from breast cancer remains the same in Massachusetts, where education is known to have had an effect on the delay figure of cancer in general.

I have, however, just received the 1950 figures from Dr. Lombard, Director of the Division of Cancer, Department of Public Health in Boston. These figures show that for breast carcinoma the median interval is months, i.e., the delay figure is still 5.1 months and on the average treatment starts 6.1 months after the first symptom is noticed.

He also sent me a copy of his remarks made at the Second National Cancer Conference in answer to Dr. McKinnon's theories on early diagnosis. In these remarks he points out some of the fallacies of judging the benefit of cancer education at present by comparison of mortality figures.

Although the keeping of medical statistics has improved during the last 20 years, death certificates on which mortality figures are based are still far from accurate, and the most important figure of all the actual "Incidence of Cancer," i.e., the number diagnosed each year, is quite unknown and can only be calculated from "samples" and figures from cases seen in certain of the hospitals. In the absence of the "incidence" figure the overall mortality figure is of little value.

McKinnon compares the mortality from breast cancer in Ontario with that in England and Wales, and states that although the mortality is different the trend of the curve in all age groups remains constant, but is this correct?

Prof. Smithers (*British Journal of Radiology*, Supplement No. 4) on page 22 states, "There is a steady downward trend in the mortality rate from breast cancer in England and Wales, after correction for changes in the age distribution of the female population." If this is correct, it is difficult to believe that this is due solely to the better treatment of the primary growth in "non-metastasising" growths, and that it has nothing to do with the better and earlier treatment of growths that would metastasise or have already metastasised to a limited extent.

Another way of discussing the problem as to whether a "metastasising growth" can ever be cured is to use the "five-year cure rate." Nobody for a moment would suggest that because a patient survives five years without symptoms or signs of the disease he or she is "cured."

To prove scientifically that a patient is *cured* of cancer, the patient must die from some other disease or old age, and a *post-mortem* examination, which would need serial sections examined through the whole body, reveals not one malignant cell. This is true of other diseases, e.g., tuberculosis.

The 5- and 10-year "cure" rates are, however, very convenient yardsticks. There are many cases of patients living 10 years who, at the time of operation, had already *metastases present in the lymphatic glands*. In the B.E.C.C. series of cancer of breast, Stage II, i.e., with lymph glands involved, the five-year cure rate is 35.1, which hardly supports the idea that nothing can be done for metastasising tumours.

Is there evidence of any relationship between (1) the delay in the treatment after symptoms are noticed; (2) the stage of the disease; (3) the five-year "cure" rate? Figures from the Royal Cancer Hospital which appear in the article by Prof. Smithers, already quoted, answer this question (Table III).

If Dr. McKinnon's suggestion that there are two classes of tumour (a) rapidly metastasising and (b) non-metastasising is correct, all cases in Stage I must be of type B, and all cases in Stages II, III and IV must have had lymphatic metastases when symptoms were first noticed. Is it not more probable that there are different rates at which growths metastasise and that had all these patients been seen under six months from the time the symptoms were first noticed many more would have been in Stage I.

It will be noted that the percentage of Stages I and II rises again after two years' "delay period." This is to be expected as it is only patients with the very slow-growing and slow-metastasising growths who would be alive after such delay before treatment. For the same reason the five-year survival rate goes up in patients who have delayed over one and a half years. This is *not* evidence against the value of early diagnosis.

Some people have used the article by Swinnerton and Truelove (*B.M.J.*, February, 1952) to suggest that early diagnosis is useless. In this article the authors state that the results of treatment of carcinoma of stomach is better in those patients who had a long pre-operative history



TABLE III

Duration of symptoms in months before consultation	Number of patients	Percentage in Stages I and II	Percentage in Stages III and IV	Percentage un-staged
Under 6 ...	364	64	31	5
Between 6 and 12 ...	173	45	49	6
Between 12 and 18 ...	98	32	62	6
Between 18 and 24 ...	34	23	65	12
Between 24 and 30 ...	53	30	68	2
Over 30 ...	75	25	76	0
Not recorded ...	49	65	18	27
	846			

RELATION BETWEEN PROGNOSIS AND DURATION OF SYMPTOMS

Duration in months	Number of patients	Five-year absolute survival rate
		Per cent.
Under 6 ...	364	43
Between 6 and 12 ...	173	28
Between 12 and 18 ...	98	26
Between 18 and 24 ...	34	41
Between 24 and 30 ...	53	26
Over 30 ...	75	33

than those with a shorter history of symptoms. The authors realise the fallacy of such a suggestion and go on to say "This finding should not be taken to indicate that early diagnosis is of little consequence. On the contrary, we believe that every effort should be made to shorten the time between the onset of symptoms and the making of the diagnosis."

Turning now to observation on experimental animals, Hadow (*Journal of Pathology and Bacteriology*, 47, No. 3, 1938) observed 336 spontaneous tumours in mice, of which 331 were mammary gland tumours. Among his conclusions are the following: "A significant correlation was found between tumour size and incidence of metastasis."

"The duration of the primary tumour was found to be a highly important single factor in determining the occurrence of metastasis."

Foulds, in his lecture (*Annals of R.C.S.*, 1951, page 93), points out that it is a mistake to think of malignancy as a single definite state in a tumour, but it should be considered as a number of different changes in a tumour, some of which are reversible, and these characteristics he labels "Responsiveness," while others are non-reversible and the characteristic of which he calls "Progression," and that responsive tumours may undergo progression to the unresponsive state.

Although Foulds is dealing with animal observations, an example has been shown in human beings in the case of "Carcinoma *in situ*" of the cervix uteri. There is little doubt that "responsiveness" with "regression," and "progression" to true invasive cancer have been observed.

Among Foulds' summary are the following statements: "At its first clinical appearance a tumour may be at any stage of progression."

"Progression may be abrupt or gradual."

Since it is impossible to say to what stage of "progression" a tumour has reached when symptoms first arise, surely it is essential to remove the tumour or destroy it as soon as it gives rise to symptoms and to do everything possible to avoid an average delay of six months.

Dr. Ludford, when asked, stated that in his experience, based on tumours in laboratory animals, he has found that some tumours metastasise early and others late or not at all. Even transplantable tumours, which rarely metastasise before the growth ulcerates, may ultimately give rise to secondary growths if the animals can be kept alive for a long period.

There is yet another argument in favour of obtaining the earliest possible diagnosis, and that is to help in the successful treatment by chemotherapy. In experimental tests of at least one chemical on animals it has been found that once the growth has attained a certain size the treatment ceases to be of the same value. This is probably true also of secondary deposits.

### Conclusions

The evidence available suggests:—

(1) That cancer education will not increase apprehension and fear of the disease but, on the contrary, will diminish them.

(2) It is unlikely to increase the work of the general practitioner.

(3) It will not increase the number of beds required, but owing to a shorter stay in hospital for "early stage" cases may diminish the number required for cancer cases.

(4) That if and when chemotherapy comes into practice the advantage of early diagnosis will be considerable.

(5) That although it is true that many growths metastasise before giving rise to symptoms, others would metastasise at a later date if left untreated.

(6) That it will produce earlier diagnosis, resulting in many more patients being treated whilst the disease is still in an 'early stage' and thus many lives will be saved.

How many lives will be saved can only be ascertained by organising a properly conducted Cancer Education Campaign.

The effect of such a campaign must be judged: (i) by any change in the 'delay figure'; (ii) by the number of patients treated in the 'early stages' of the disease; (iii) by the 'five year survival rate'; (iv) eventually by the mortality figure. The last criterion for reasons already mentioned is difficult to estimate accurately.

### BOOK REVIEWS

#### Food Safety First—A Hygiene Code for the Canteen.

Issued by the Industrial Welfare Society, 48, Bryanston Square, London, W.1. Price 1s.

The authors of this booklet have had medical advice in its preparation and, apart from a few minor errors, these 24 pages bring the facts of food poisoning home to the food-handler in simple language which can readily be understood by the average canteen worker. The layout and type-setting are most attractive.

It is, perhaps, unfortunate that the handling of money had to be mentioned, for in the smaller type of food premises where no cashier can be employed, there is meantime no solution of the problem. The recommendation that remains of a suspected meal and the utensils used should be retained for investigation, is one which might be followed more conscientiously.

An omission is the lack of mention of the anti-fly measure of a naturally dark larder, lighted only by artificial means as necessary, while more might have been made of the elimination of breeding places attractive to the housefly and to other insects. The susceptibility of cat and dog, again, to the Salmonella food-poisoning infections, might have been included.

The reference to refrigeration of meat pies is also unfortunate; the trade affirm that a slate shelf in a cool room is all that is necessary and that refrigeration adversely affects the palatability of both pastry and jelly. The real point is that they should not be accessible to flies. The question of the safety of placing reconstituted dried egg in a refrigerator may also be criticised—it should be cooked or otherwise used as soon as it has been reconstituted, as advised on the container.

These comments apart, this booklet is worthy of the attention of management and canteen staff, while self-analysis on the lines set out would be time well spent.

**British Standards Yearbook, 1952.** (Pp. 400. Price 7s. 6d., post free.) London: British Standards Institution, 24, Victoria Street, S.W.1.

The work of the B.S.I. in laying down standards for all manner of goods, equipment and machinery by the method of consultation and agreement is well known. Its standards cover much hospital equipment, building materials and other items of interest to us. The *Yearbook* contains short descriptions of all standards agreed and other relevant information up to March 31st, 1952.

# SOCIETY OF MEDICAL OFFICERS OF HEALTH

## Notice of Provincial Ordinary Meeting

Notice is hereby given that an Ordinary Meeting of the Society will be held in the City Chambers, Edinburgh, on Saturday, July 19th, 1952, at 10 a.m., preceding a joint meeting with the Scottish Branch, when Prof. Sir James Learmonth, K.C.V.O., O.B.E., F.R.S.E., CH.M., F.R.C.S. ED., will give an address.

### AGENDA

1. Minutes.
2. Correspondence.
3. Election of the following as fully-paid Life Members, on the nomination of the Council and of their Branches:—  
*Home Counties' Branch*.—Dr. Rutherford Cramb, formerly M.O.H., Brighton C.B., joined the Society 1922.  
*North-Western Branch*.—Dr. James Walker, formerly Deputy M.O.H., Preston C.B., joined the Society 1920.  
*Scottish Branch*.—Dr. G. V. T. McMichael, formerly M.O.H., Paisley Burgh, joined the Society 1913.
4. Election of Fellows and Associates (list of candidates below).
5. Nominations.
6. Any other business.

By Order,  
G. L. C. ELLISTON,  
Executive Secretary.

Tavistock House South,  
London, W.C.1.  
June 17th, 1952.

## Candidates for Election, July 19th, 1952

### FELLOWS

- ASTON, Elizabeth Oliver, L.M.S.A.A. (LOND.), 65, High Street, Netherton, Dudley, Worcs. Asst. C.M.O. Staffs C.C. (T.O.P.D. Lawson, G. Ramage.) (*Mid*)
- BRAID, Grace Fides Matilda, M.B., CH.B. (GLAS.), D.P.H., DOBIST. B.C.O.C., Health Department, 6, George Street, Kilmarnock. Asst. M.O.H., Kilmarnock. (B. R. Nisbet, R. L. Leask.) (*Sc*)
- COULTER, Elizabeth Johnstone, M.B., CH.B. (GLAS.), 1, Norreys Avenue, Abingdon Road, Oxford. Asst. M.O.H. and Asst. S.M.O., Oxford C.B. (J. F. Warin, M. Fisher.) (*H.C.*)
- FAY, Leo, M.D., M.B., CH.B., D.P.H. (LOND.), High Bank, Trull, Taunton, Somerset. Dep. C.M.O., Somerset and M.O.H., Taunton M.B. (T. Pierson, R. H. G. H. Denham.) (*W.E.*)
- GAYE, Wilhelmine Norah, M.B.C.S. (ENG.), L.R.C.P., D.P.H. (LIV.), Mardon, Pen-y-Garth, Caernarvon N. Wales. Asst. C. and S.M.O., Caernarvonshire C.C. (M. Slater, G. W. Roberts.) (*N.W.*)
- HICKSON, Violet L. deA., M.R.C.S. (ENG.), L.R.C.P., D.P.H. (WALES), 35, Bridge Street, Hereford. Asst. M.O., Hereford C.C. (H. Sainsbury, J. S. Cookson.) (*Mid*)
- LINNELL, Phyllis Mary, M.B., CH.B. (BIOM.), M.R.C.S., L.R.C.P., D.P.H., 19, Tower Road, Twickenham, Middlesex. Asst. M.O., Middlesex C.C. (J. Maddison, W. Cormack.) (*H.C.*)
- LOWE, Greta, M.B., CH.B. (MANCH.), D.T.M. & H., Resthaven, Marine Drive, Barton-on-Sea, Hants. Asst. C.M.O.H., Hampshire (Part-time). (D. J. N. McNab, E. J. Gordon Wallace.) (*S*)
- MCLEROY, Robert Samuel, M.B., B.CH., B.A.O. (DUBLIN), D.P.H., D.T.M., 17, Bath Road, Swindon, Wilts. M.O.H., Highworth and Cricklade and Wootton Bassett R.D.C.s and Asst. C.M.O., Wit's C.C. (R. MacKay, J. Urquhart.) (*W.E.*)
- MATHESON, Kenneth William, M.B., CH.B. (EDIN.), 70, Corstorphine Road, Murrayfield, Edinburgh, 12. Asst. M.O. (M. & C.W.), City of Edinburgh. (H. P. Tait, M. E. Sturrock.) (*Sc*)
- O'FLYNN, Patricia Mary, M.B., B.S. (SYDNEY), 106, Ryde Road, Pymble, Sydney, N.S.W., Australia. M.O., Department of Health, N.S.W. (S. Reppin, E. Meyers.) (*N.S.W.*)
- PATERSON, John Thomson, M.B., CH.B. (EDIN.), 7, Oaklands Avenue, Romford, Essex. Consultant, Diseases of the Chest, Barking and Dagenham Chest Clinic. (C. Herington, F. G. Brown.) (*H.C.*)
- PYZIK, Michalina Bronislawa, B.D.S. (BRISTOL), Woolwich Health Centre, Market Street, London, S.E.18. D.O., L.C.C. (J. F. A. Smyth, J. V. Bingay.) (*Met*)
- RICHARDS, Hilda M., M.R.C.S. (ENG.), L.R.C.P., 59, Benhurst Court, Leigham Court Road, London, S.W.16. Asst. M.O., L.C.C.; Lecturer (Public Health), Battersea Polytechnic, S.W.11. (D. A. Craigmile, G. E. Wilkinson.) (*Met*)
- ROBERTS, Constance Eveyn, M.B., B.S. (LOND.), M.R.C.S., L.R.C.P., Upfield, Winscombe, Somerset. Part-time Asst. M.O.H., Bristol. (R. C. Wofinden, R. H. Parry.) (*W.E.*)

- STEVENSON, Margaret Scott, M.B., CH.B. (EDIN.), D.P.H., 45, Devonshire Street, London, W.1. Dep. M.O.H. and Asst. M.O., L.C.C., Div. 3. (C. O. S. Blyth Brooke, J. E. Marshall.) (*Met*)
- WALSH, Elizabeth, M.B., B.S. (LOND.), 14, Essex Gardens, Gateshead 9, Co. Durham. Asst. Welfare M.O., Durham C.C. (W. S. Walton E. S. Williamson.) (*N*)
- WALSH, Nannie Christina, M.B., B.CH., B.A.O., D.C.H., 38, West Cromwell Road, S.W.5. Asst. M.O., L.C.C. (D. Egan, M. T. Paterson.) (*Met*)
- WHITFIELD, Audrey P., M.B., B.S. (LOND.), "Cornerways," 1, Barlow Road, Hampton-on-Thames, Middlesex. Asst. M.O., Middlesex C.C. (J. Maddison, W. Cormack.) (*H.C.*)
- WILSON-MURPHY, Hannah, M.B., B.CH., B.A.O., D.P.H. (CORK), 207a, Sutherland Avenue, London, W.9. Asst. M.O., L.C.C. (A. Mower White, M. S. Gillatt.) (*Met*)
- WOODS, Grace E., M.B., B.S. (LOND.), D.P.H., D.C.H., 21, Downs Cote View, Westbury-on-Trym, Bristol. Part-time M.O., Bristol P.H.S., Clinical Assistant (Research), Department of Child Health, Bristol. (R. C. Wofinden, R. H. Parry.) (*W.E.*)

### ASSOCIATES

- BLUMENAU, Ernest, M.D.U. (FRANKFURT), The Rectory, Woughton-on-the-Green, Blechley, Bucks. School D.O., Bucks C.C. (E. Kew, K. C. B. Webster.) (*H.C.*)
- EVANS, William David Percival, L.D.S., R.C.S. (ENG.), Tyn-y-Lon, Rhydyfelin, Aberswyth, Cards. Senior D.O., Cardiganshire C.C. (I. M. Watkin, E. Jones.) (*Wa*)
- SCHROTTER, Theresa, M.D. (VIENNA), 388, Upper Richmond Road, London, S.W.15. D.O., Middlesex C.C. (M. Cohn, I. F. A. Smyth.) (*H.C.*)
- SQUIRES, Dorothy Winifred, L.D.S., R.F.F.S. (GLAS.), Fairacre, Harcombe Hill, Winterbourne, Bristol. D.O. Glas. C.C. (J. F. A. Smyth, J. V. Bingay.) (*W.E.*)

### REPORTS

#### MIDLAND BRANCH

*President:* Dr. C. Starkie (M.O.H., Kidderminster; Div. M.O., Worcs.)

*Hon. Secretary:* Dr. W. Alcock (M.O.H., Burton-on-Trent C.B.)

The fifth meeting of the session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, March 6th, 1952, at 3 p.m. The President was in the chair and 31 members attended.

#### Preventive Aspects of Mental Health

An address was given by Prof. J. M. Mackintosh on the above subject. In a brief historical survey Prof. Mackintosh referred to the early methods of ascertainment of mental disorder, when the chief criterion was apparently whether the patient was a nuisance to his family or to the community, and to the methods of treatment, the armamentarium of which consisted of irons, stocks and manacles.

In the 18th century the Bethlem Hospital used to make a charge of 2d. to see the lunatics and raised the considerable income of £400 a year from this source. Treatment consisted in the main of bleeding, vomiting and purging, but gradually a more humanitarian approach to the problem of mental illness developed.

Later developments were the separation of mental defectives from persons of unsound mind, and, in more recent years, the voluntary admission of patients to mental hospitals.

Turning to the preventive side of mental health, Dr. Mackintosh stressed the necessity of first acquiring a knowledge of the root causes of mental illness and, since the child is the father of the man, of commencing with infants, if we are to develop a truly preventive Mental Health Service.

At the present time there are no reliable indices for the assessment of mental illness comparable with those of physical ill-health, and there is a large field for research. The extent of psychoneurotic illness is enormous and is said to account for one-third of all long-term illness.

What are urgently required are planned surveys of psychoneurosis, with special reference to such matters as studies of suicide rates, differentials in sex, religion, social circumstances and age, and the impact of such aspects of fear of unemployment, threat of war, or threat of national instability. Progress is hampered at the present time, however, by the lack of trained personnel and the shortage of well-equipped clinics.

An interesting discussion followed, in which Drs. Jean Mackintosh, Owen, Galloway and Savage took part.

There was general agreement that a beginning should be made with the mother and child, and that Health Visitors, by nature of their experience and training, could do a great deal on the preventive side.

A hearty vote of thanks was accorded to Prof. Mackintosh by Dr. Pickup for his most interesting and stimulating address. This was seconded by Dr. Markham and approved unanimously.

### Nomination for Presidency

Consideration of this matter having been deferred from the last meeting, it was proposed by Dr. Galloway, seconded by Dr. Griffin, and agreed, that this Branch support the nomination of Prof. A. Topping for the office of President for the session 1952-53. It was, however, proposed that a representation be made to the Executive Secretary, that the practice of circulating nominations for Presidency from other Branches be discontinued and that at an appropriate time a complete list of nominees be submitted by the Executive Secretary to all Branches.

### NORTH-WESTERN BRANCH

President: Dr. A. M. Grierson (Dep. M.O.H., Manchester C.B.).

Hon. Secretary: Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

An ordinary meeting of the Branch was held in Manchester on Friday, March 14th, when 29 members were present.

It was duly moved and seconded that Dr. James Walker, sometime Deputy Medical Officer of Health of the County Borough of Preston, having been a member of the Society of Medical Officers of Health since 1920, be recommended to the Council for nomination for fully-paid life membership.

A letter from the Honorary Secretary of the Metropolitan Branch, dated February 21st, intimating that the Branch had unanimously decided to nominate Dr. Andrew Topping for the Presidency of the Society for the year 1952-53, was read, and it was agreed to support Dr. Topping's nomination to the Presidency.

Prof. C. Fraser Brockington then delivered an address on "Some Observations on American Medicine from the Point of View of a Medical Officer of Health."

An ordinary meeting was held at the Municipal Building, Preston, on Friday, April 4th, when 17 members and guests attended.

In the absence of the President the chair was occupied by Dr. J. E. Spence, the senior Past-President in attendance.

### Accidents in the Home

The Chairman then introduced Dr. C. A. Boucher, Medical Officer at the Ministry of Health, who gave a talk on the above subject.

He gave an outline of the size of the problem and its gravity in comparison with road accidents and referred to the heavy incidence amongst those under five and over 60 years of age. Reference was made to the occurrence of burns and scalds and accidents from domestic machinery in children, from burns and falls in old people, and to the rise in accidents in the third quarter of the year.

He spoke of the influence of ignorance of the proper use of apparatus and carelessness in its use was referred to as a common cause of trouble. Dr. Boucher thought that the figures from other countries suggested that the type of accident was very much in the same proportion elsewhere as here.

Among preventive measures discussed with a view to reducing the number of accidents was the compulsory fitting of guards to household fire appliances, the flash point of materials used in making garments and the education of the public in such factors as the frequency of scalding of infants from a cup of tea. It was felt that considerable propaganda was necessary and that lectures to mothers in welfare centres and to older school-children would be valuable contributions to the solution of the problem.

Dr. Wade suggested shock tactics in propaganda, but Dr. Robertson was pessimistic about the value of education on this subject.

Dr. Wood was optimistic about the effect of education of the young, but was less so in respect of elderly persons.

Dr. Crawford thought that local health authorities should be pressed to take more active steps to acquaint the public with the true position. He referred also to the frequency of falls in elderly women who were subsequently found to be wearing ill-fitting badly-worn shoes.

Dr. Hilditch happily expressed the thanks of the meeting to Dr. Boucher for an instructive address, which had brought to our notice a subject that was well within the field of public health and about which a good deal more could be done.

An ordinary meeting of the Branch was held at the Castle, Chester, on Friday, May 9th, 1952, when 39 members attended.

The Honorary Secretary advised the proposed establishment of an area committee to deal with medical manpower in time of war and the following nominations were agreed to:—

Drs. R. B. Berry, A. Brown, F. W. C. Brown, J. S. G. Burnett, R. W. Eldridge, S. C. Gawe, A. M. M. Grierson, J. Innes, E. M. Jenkins, G. H. Potter, A. S. Simpson, V. T. Thierens, K. K. Wood, J. Yule.

### The School Leaver and His Entry into Industry

The President then introduced Dr. J. N. Macdonald, Senior Medical Officer, Lever Brothers, Port Sunlight, who spoke on the above. Having reviewed the history of the school health service he drew an analogy between it and the present development of the industrial health service and argued the need for the successful interlocking of the two services. There was a profound need for the study of leavers from school and young entrants into industry. Proper reception into industry was of paramount importance and the mental approach was valuable inasmuch as the important senior school in a matter of 24 hours became an unimportant small boy in a new environment. It was essential, therefore, that the new entrant should immediately be given contacts in the shape of his future supervisor and fellow-workers and that he should be taken to see the job that was to be done. Having been given information about his future job it was essential that he should then go on a course in the training department of the industry where he could learn the history of the firm, its policy and the amenities available to him and what was expected of him in return. The blind-alley jobs had to be watched and facilities through the medium of evening classes provided to enable the more ambitious to graduate to more responsible posts.

The medical examination should not exist solely for the purpose of rejecting unfit persons. Where persons were going to be employed the examination should determine the suitability of the candidate for particular types of employment so that he was not placed where he would be harmful to himself or others, but a main purpose was to establish a relation between employer and employee. In his own factory Dr. Macdonald indicated that whilst the initial medical examination was compulsory, from then on attendance at the medical department was entirely voluntary.

He then proceeded to discuss certain observed factors such as the extremely high incidence of infested heads amongst entrants, the higher absentee rate amongst those under 18 years and the higher accident rate due to susceptibility to intercurrent family infections, to ignorance of the job being done and to youthful irresponsibility. He spoke of the individual problems arising from the material physical defect and discussed the assessment of ability and the means provided whereby an ambitious, hard-working girl could progress to higher levels of activity.

A lively discussion ensued on the question of infested heads, in which Dr. Macdonald emphasised the need for adequate inspection and for a recognition of the fact that the presence of ova was proof of infestation.

Dr. Arnold Brown congratulated Dr. Macdonald on the excellence of his paper and thought that in view of the tremendous disability to-day from psychological causes this approach to the problem was excellent prophylaxis. He wondered whether Dr. Macdonald had any comments to make on the effect of school dentistry as seen in later adolescence and asked for his views on the employment of persons with open tuberculosis.

Dr. Macdonald, in reply, said he could not speak on specific standards, but his impression was that youngsters coming into industry during the war were dentally fitter than those coming in to-day. As to the question of open tubercle, he thought that risk was great and whilst he had his own views as a medical man it was clear that the management had to bear very much in mind the possible rather than the probable risk and the issues involved.

Further discussion took place on group intelligence testing and Dr. Macdonald indicated that both group testing and group discussions were used fairly extensively.

Dr. Yule queried their value, inasmuch as the interpretation of the test was even more important than its setting up and he wondered whether the examiners were fully competent to interpret the results of the test, but Dr. Macdonald indicated that the tests were used only as a general guide and other factors were given infinitely greater weight.

Dr. Jenkins, in moving a vote of thanks to Dr. Macdonald, said that we had been shown a picture of tremendous advance in industrial health work and he complimented Dr. Macdonald on the splendid work that was being done by him and his staff for a firm that had always been well in advance of the time.

The President, in closing the meeting, expressed pleasure at the success of this first meeting in Chester, and expressed the view that its success justified its annual repetition. We were indebted to Dr. Arnold Brown for the excellent arrangements he had made for our reception.

#### NORTHERN BRANCH

*President:* Dr. J. V. Walker (M.O.H., Darlington C.B.).

*Hon. Secretary:* Dr. W. S. Walton, G.M. (M.O.H., Newcastle-on-Tyne C.B.).

A meeting of the Branch was held in Newcastle-on-Tyne on Thursday, May 15th, 1952. The President and 27 members were present.

*Medical Manpower Committee.*—Consideration was given to the request from headquarters for three extra nominations and it was agreed that the names of Dr. W. J. Pierce (Northumberland C.C.) and Dr. W. S. Walton (Newcastle C.B.) be submitted. The Northern Sub-Group of the County District Group was asked to submit the third nomination for Urban and Rural Districts. (The Sub-Group later nominated Dr. C. B. McGregor (Morpeth).)

*Diploma in Public Health.*—The Honorary Secretary gave details of the course for the D.P.H. and C.P.H. which it was proposed to start in October at King's College if sufficient candidates presented themselves.

*Report of Representative on Council.*—The Branch's representative reported on matters which had been considered by the Council of the Society.

*Annual Summer Meeting.*—It was agreed that the annual summer meeting take place at Barnard Castle on Friday, July 4th, 1952.

*Dysentery Survey and Law re Illegitimate Children.*—Correspondence between Dr. E. C. Downer (Middlesbrough) and the Executive Secretary re inadequate representation of Medical Officers of Health on two recent committees of enquiry into, firstly the cause and spread of dysentery, and secondly the law as it affects legitimate children, was discussed. Members generally favoured co-operation if asked for information by such committees.

*Integration of Local Health Authority and Regional Hospital Board Clinical Staffs.*—Consideration was given to a suggested scheme whereby clinicians in Local Health Authority clinics would be given the opportunity to work part-time in hospitals, the Local Health Authority offering similar opportunities in their own clinics to junior hospital officers. It was agreed that the principle be accepted and that the Regional Hospital Board be asked to make such joint appointments available.

*Letters to PUBLIC HEALTH.*—The Branch received the report of the Council on correspondence between Dr. G. H. Shanley and the Editor of PUBLIC HEALTH. It was agreed that although extracts only of Dr. Shanley's letter on the Industrial Court award as it affects junior medical officers were published, the Editor's action in doing so was in accordance with the accepted practice of editorship. Dr. Shanley reiterated his view that the Editor's action stifled expression of dissatisfaction at the Court award and was in effect a form of censorship.

*Correspondence.*—For the information of members, the President submitted correspondence between Dr. A. Forster (Chester-Stree) and the Ministry of Agriculture and Fisheries on the use of bacterial cultures in rodent control, and a further letter from Dr. Forster on subscriptions to the Society and improvements in the publication of PUBLIC HEALTH.

*Durham C.C. Closed Shop.*—Referring to the British Medical Guild fund available to assist medical officers who had suffered financial loss as a result of their acceptance and subsequent withdrawal from the Durham C.C. black-listed appointments, Dr. Shanley stated that payment in full had not been made to these officers. It was agreed that the Honorary Secretary obtain information from the British Medical Association as to why part payment only was being made.

#### WELSH BRANCH

*President:* Dr. W. P. Phillips (Dep. M.O.H., Cardiff C.B.).

*Hon. Secretary:* Dr. R. T. Bevan (Dep. M.O.H., Glamorgan C.C.).

A meeting of the Branch was held at B.M.A. House, Cardiff, on February 28th. There were 14 members present.

In the absence of the President, Dr. G. McKim Thomas acted as chairman and introduced Dr. Rupert Parry, who addressed the meeting, choosing as his subject "Common Eye Conditions in Childhood."

Dr. Parry, in opening his remarks, pointed out that many of the eye conditions which in the past could be regarded as common were now becoming rare. Preventive measures were eliminating eye diseases due to syphilis and gonorrhoea. Many of the defects now observed were inherited. Dr. Parry regarded it as a mistake to regard many people with myopia as being severely handicapped, and he illustrated his point by reference to well-known sportsmen who had severe degrees of myopia.

He discussed the treatment of squints and emphasised the importance of orthoptic treatment.

Chronic blepharitis was becoming increasingly rare, but an essential part of its treatment was the correction of the refractive error.

Dr. Parry discussed the aetiology of conjunctivitis and pointed out the difference in the response to treatment when the conjunctivitis was due to a virus infection. (Pneumococcal infection responding in one week as compared to three or six weeks in a virus infection.)

After a lengthy discussion period, a vote of thanks was proposed by Dr. Gladys Evans and seconded by Dr. D. Trevor Thomas.

A meeting of the Branch was held at the Public Health Clinic, Llandrindod Wells, on May 3rd, 1952. There were 17 members present and in addition three visitors.

The President introduced Dr. Wynne-Griffith, who addressed the meeting on "The Case for Fluoridation."

The speaker put forward a plea that fluorine should be added to water supplies which were deficient in this respect. He gave examples of its introduction, particularly in America. Following the address there was a lively discussion in which many members took part. The question of caries in teeth was discussed from a variety of angles. The possibility of fluorine being added to various foods was mentioned. (Dr. Wynne-Griffith's paper was published in PUBLIC HEALTH, June, 1952, page 152.)

Dr. Culley proposed and Dr. Anderson seconded a vote of thanks to the speaker.

On May 4th Dr. Crawford, M.O.H., Radnorshire, conducted members of the Society and their wives on a tour of the Birmingham Reservoir, which was nearing completion.

#### DENTAL OFFICERS' GROUP

*President:* J. V. Bingley, M.B.E., L.D.S. (Chief D.O., Middlesex).

*Hon. Secretary:* J. F. A. Smyth, L.D.S. (Chief D.O., Gloucestershire).

A meeting of the Group was held in the Society's Rooms at Tavistock House South on Saturday, February 2nd, 1952, at 2.15 p.m. The President, Mr. J. V. Bingley, was attending a meeting of the General Dental Services Committee of the British Dental Association and Local Dental Committees, and the chair was taken by Mr. P. G. Oliver, the Immediate Past-President. Also present were 20 members and visitors.

Apologies for absence were received from Miss A. M. Stewart and Messrs. E. Kew and J. Young.

#### The Conservation of the Deciduous Teeth

After the reading and confirmation of the minutes, Mr. P. G. Oliver introduced the speaker, Mr. G. Scott Page, L.D.S., and invited him to read his paper on the above subject. He said that many practitioners showed a lack of interest in children's dentistry. The work was less remunerative perhaps and had not the glamour or oral surgery, nevertheless it was of importance and aimed at the maintenance of masticatory surfaces, the avoidance of toothache and focal infection, the maintenance of spaces for the permanent dentition, and with all this to keep the confidence of the child for years to come. It was important that the work should be well done as the fillings had in many cases to last five or six years. He stressed the importance of careful diagnosis at the first visit and the need for bite-wing x-rays to disclose early proximal cavities. After the first visit it should be known which teeth were to be extracted, whether space retainers were required, the possibilities of partial pulpectomy and how many teeth were to be filled. The teeth that were then filled, if seen regularly, should be exfoliated naturally. Mr. Scott Page favoured the use of local anaesthesia for fillings in deciduous teeth, the mandibular injection in the lower jaw and infiltration for the upper teeth. Sometimes he worked under endo-tracheal anaesthesia on the operating table. With difficult children he recommended the giving of  $\frac{1}{2}$  grain of seccal one hour before the time of the appointment. In 90% of the cases the filling material of his choice was silver amalgam, but in more extensive cavities he used gold or silver inlays. Mr. Scott Page illustrated his talk with the epidiascope showing bite-wing x-ray films and details of the technique of cavity preparation. Models were also passed round for individual examination. An interesting discussion followed in which seven



members took part. A vote of thanks to Mr. Scott Page was proposed by Mr. A. G. Taylor, seconded by Mr. J. C. Robertson, and carried by acclamation. The date of the next meeting was provisionally fixed for May 10th, 1952.

**Group Council.** A meeting of the Group Council was held at Tavistock House South on Saturday, February 2nd, 1952, at 10 a.m. Owing to the absence of the Chairman (Mr. J. V. Bingay), who was attending a meeting of the General Dental Services Committee, Mr. K. C. B. Webster presided. Also present were Messrs. K. Batten, M. Cohn, R. B. Dinsdale, S. K. Donaldson, J. Fletcher, P. G. Oliver, J. C. Robertson, J. F. A. Smyth, A. G. Taylor and T. H. Lipstrot (observer from the P.D.O. Group of the British Dental Association).

Apologies for absence were received from Messrs. E. Kew, H. B. Fleming, J. Young and Miss A. M. Stewart.

In opening the meeting Mr. Webster voiced the congratulations of the meeting to Mr. A. G. Taylor on his election as President of the sister Group in the British Dental Association.

The minutes of the previous Council meeting were read, confirmed and signed.

Arising from the minutes the Hon. Secretary reported that a letter had been received from the Secretary of the Standing Dental Advisory Committee stating that the experiment in the use of oral hygienists had been completed and the sub-committee having presented its final report was now disbanded. Any members who were interested could visit the Eastman Dental Hospital where the courses for the training of oral hygienists were taking place.

#### *Report of the General Purposes Committee of the Group.*

(1) The Society had been requested by the Ministry to forward two nominations for vacancies on the Standing Dental Advisory Committee of the Central Health Council. The matter had been referred to the Group, and the names of Messrs. Bingay and Fletcher had been sent forward.

(2) The British Dental Association had asked for a nomination for a representative of the Society on the General Dental Services Committee. Mr. J. V. Bingay's name had been forwarded, and Mr. Smyth appointed his deputy.

The action taken by the General Purposes Committee was confirmed.

#### *Report of Group Representatives on Council of the Society.*

Mr. A. G. Taylor reported that the size of the General Purposes Committee had been reduced to 15, but it had been agreed that one of the members should be a Dental Officer and he had been re-elected. Other matters on which Mr. Taylor reported were the formation of an Advisory Committee on Research, the Oral Hygienists Experiment, the Whitley Council, the Derbyshire "Closed Shop" policy, the Group's memorandum on the Dentists Bill, which had been accepted by the Council and forwarded to Lord Woolton and other interested bodies, and dual appointments under Regional Boards and Local Authorities.

Mr. Taylor also referred to the retirement of Sir Allen Daley and the election of Dr. J. M. Gibson as Chairman of the Council. The Hon. Secretary was instructed to write to Sir Allen Daley conveying to him the Group's good wishes for a long and happy retirement.

The Hon. Secretary was also instructed to write to the Executive Secretary asking whether consideration could be given to the British Dental Association's being added to the list of bodies who should be informed of the setting-up of the Society's Advisory Committee on Research.

**Report of Hon. Treasurer.**—Mr. A. G. Taylor reported that the cost of Council meetings had been somewhat reduced owing to the implementation of the recommendations of the Economy Committee. A number of accounts were approved for payment.

**Report of Hon. Editor.**—Mr. Fletcher said that Mr. H. D. Freeman's paper on "Orthodontics in the School Clinic" had been accepted for publication in PUBLIC HEALTH.

**Report of Joint Salaries and General Purposes Committee.**—The Committee had met and considered the provisions of the Dentists Bill. A number of members had submitted memoranda. A joint statement of policy had been drawn up and submitted to the Council of the Society, by whom it had been approved.

**The National Health Service Bill, 1952.**—The Bill was discussed particularly in relation to the proposed £1 charge for dental treatment from which children and expectant and nursing mothers were to be exempt. The matter was referred to the Joint Salaries and General Purposes Committee.

**General Dental Services Committee.**—Mr. Bingay reported that he had been co-opted to the Health Acts, Remuneration and Health Centres Sub-committee, and that Mr. Mason had been elected to the Remuneration Sub-committee. The Health Centre Salary Scale had been revised in the light of the Dental Whitley Council's Salary Scales.

## MATERNITY & CHILD WELFARE GROUP

**President:** Dr. Anna B. Gardner (Sen. M.O., N.C.W., Kent).

**Secretary:** Dr. Kathleen Hart (A. Div. M.O., Middlesex).

**Assist. Secretary:** Dr. Doris Craigme (A. Div. M.O., Middlesex).

A general meeting of the Group was held in the Old Library, B.M.A. House, on Saturday, April 5th, 1952. Twenty-three members were present.

### **The Rockefeller W.H.O. Study on Workers to Meet the needs of the family**

The President was in the chair and introduced the speaker for the afternoon—Prof. Leslie Banks, Professor of Human Ecology in the University of Cambridge, who came to tell us about the inception of the Pilot Study sponsored by the Rockefeller Foundation and the World Health Organisation. The following is a summary of his address:—

The object of the survey is to obtain information regarding the number and types of health and welfare workers best qualified to meet the various needs of the family compatible with economy and efficiency. The investigation, which will end in October, 1953, is being undertaken by two teams of workers in France and in England, under the overall direction of Prof. René Sand. The team working in England is led by Prof. Banks and the team in France by M. Girard.

The project was first mooted in Canada and the United States, but it was finally decided to make studies in these two countries, which have a common cultural background but use different methods of training and employing social workers.

Prof. Banks outlined the history of medico-social work in France, which began with Caimette's drive against tuberculosis at the beginning of the century. In 1923 medico-social workers had been recognised and a State diploma awarded; later, social workers had been granted diplomas. In 1938 the training for these two types of workers had been unified into a single basic training, and those qualifying from the courses were known as "assistantes sociales," who worked in the health teams of the various "départements" into which France is divided. They were the mouthpiece of the physicians and dealt with the moral, social and economic rehabilitation of the family, and were able to call on the help of workers who specialised in various aspects of the work. Their duties also include collaboration with other public and private undertakings.

Prof. Banks went on to explain that the organisation in France was highly centralised, the Ministry of Public Health closely co-ordinating the Departmental Boards of Health, the *Préfets* of which were in almost daily touch with the Ministry. Each *département* has a Social Hygiene Service which deals especially with cancer, venereal disease, tuberculosis, maternity and child welfare and mental disease. The *départements* are subdivided into regions of approximately 8,000—10,000 population and each has a polyvalent social worker (or *assistante sociale*) and a number of specialist medico-social workers. There are more than 5,000 *assistantes* with the State diploma employed in the *départements*. In addition there are another 1,000 social workers employed by private organisations who undertake public work by agreement. The German occupation speeded up the integration of the service and by a Law of August, 1950, compulsory committees were set up for liaison and co-ordination of social services in each *département*.

There are about 60 schools which offer a three-year training course, at the end of which a State diploma is awarded, enabling the recipient to work as an *assistante sociale*. The first year of training is similar to that for the nursing diploma, while the following years are spent in studying such subjects as sociology, law, economics, demography, psychology and family and social assistance legislation. The course is both practical and theoretical. After training the *assistantes sociales* can take any post or specialise. In addition, France has 3,000 family workers who have taken a six months' course in domestic work, and who are more highly trained than our own home helps, but who fulfil a similar function.

Prof. Banks then outlined the growth of the English medico-social system. It was, he said, a multiple growth to meet any individual needs. Except in the rural areas, England had no equivalent of the polyvalent *assistante sociale*. For the preliminary enquiries the county of Bedfordshire was selected, having both rural, industrial and county town populations. The full investigating team would consist of Prof. Banks and five field workers who proposed to study the social and economic environment, the number and types of organisations concerned with family welfare and the kinds of workers employed by them. Only full-time welfare workers were included in the survey, and preliminary enquiries, which were not complete, had already revealed 24 different types of workers; and that the traditional pattern had changed because of the local activities of Government departments, including the National Assistance Board.

In Luton, too, the proportion of the various social classes was not typical of the country as a whole, for the light engineering industries increased the numbers in Social Class III, the skilled workers.

Joint meetings are held frequently with the French investigating team who, at one time, were in serious difficulty, as they were unable to obtain access to the records of the *assistantes sociales*, who were pledged to secrecy in their work. A simple basic questionnaire was evolved jointly to be used to assess the needs of the family.

The survey was then extended, in France to cover Paris, an industrial area and a rural area, and in England it is proposed to extend the survey in a similar manner. The trouble, Prof. Banks said, was not what to include in the investigation but what to omit. He expressed the hope that something would emerge from the investigation which would be of value to the backward countries.

Dr. Warwick, in proposing a vote of thanks to Prof. Banks, recalled M. René Sands' address to the Women Public Health Officers. She said that the problems put forward were of concern to all. We had had many reports of interesting surveys, but it was an unusual and valuable experience to hear of the initiation and building up of such a study and she hoped we might be privileged to hear about their findings at a later date.

#### Clinical Week-End, Oxford, May 10th-11th, 1952

Nearly 90 members gathered at Oxford for the lectures given by members of the Radcliffe Infirmary, the Institute of Social Medicine and the City Medical Officer of Health.

Saturday morning was spent at the Institute of Social Medicine.

Dr. Alice Stewart, Director of the Institute, gave a short introductory talk on the work of the Institute and on the various methods by which enquiries were made. While they could not hope to arrive at a final answer in many of their surveys, the staff of the Institute aimed at carrying the investigation one stage further.

Dr. C. Westropp, who followed her, described the survey, originated by Prof. Ryle, to watch the health and sickness experience of a group of Oxford children up to the age of five years. The physical, environmental and intelligence levels of the children were studied. Where possible, objective estimates were made. For example, in assessing maternal efficiency a household amenity rating was devised and Dr. Westropp showed that when this was low the amount of illness increased and success in breast-feeding decreased.

A study on the growth and development of these children has been made by Dr. Jessie Parfit, who gave a well-illustrated talk on this subject. She suggested that children whose weights were within the standard deviation range from the mean for their age should be classed as "normal," but that the 16% whose weights fell on either side of this range were in need of extra care. Dr. Parfit said that they were investigating the genetics of weight and height and illustrated the tendency for children to conform to the parental height and weight pattern. For instance, at five years of age 58% of the underweight group came from families where one parent, at least, was of slight build.

Dr. R. Acheson and his colleagues had been studying these children radiographically and he described the various types of skeletal maturation found. Both the change in shape and number of the carpal bones and changes in the knee joint could be used as an Index of Skeletal Maturity during the first four years of life. Maturity was related to weight and severe illnesses were one factor which delayed ossification. Neither the number of teeth nor the closure of the fontanelle could be correlated to bony development.

During the talks an opportunity was made for most of the members to see a demonstration of the Powers-Samas machines and to hear how the information gained in the field was tabulated, sorted and correlated.

A vote of thanks for a full and interesting morning was proposed by Dr. V. Mary Crosbie.

The afternoon was spent at the Slade Hospital. Members were shown round the units and returned to hear Dr. Warin, the Medical Officer of Health for Oxford, give a lecture on "Modern Trends in the Control of Infectious Disease."

Dr. Warin said that the duty laid on local authorities to control infectious disease was still of great importance, although the type of infection coming under care had changed greatly, as had the structure of the fever hospitals. The Slade Hospital

which we had just seen was one of the newest in the country and had a tuberculosis unit as well as cubicle blocks for the other infectious diseases.

The type of case requiring admission had altered and the old severe enteric diseases were now infrequent. Three main types of case requiring hospitalisation, those needing specialised medical and nursing care, those whose homes were unsuitable, and the university students. Measles, scarlet fever and whooping cough, which caused nearly half the deaths in the hospital in the last three years, were the commonest diseases requiring admission. An epidemic of Bornholm disease had occurred and there had been actually more cases of leprosy than diphtheria.

Dr. Warin deprecated routine exclusion of contacts from school. In many cases it was an advantage for the child to meet the infection at school age.

By far the most important infectious disease nowadays was tuberculosis. Methods of treatment had advanced greatly but prevention should still be the foremost aim. Such a scheme of prevention should include routine or mass x-ray of groups of the population, tuberculin jelly testing of young children. Vaccination of contacts and especially of school-leavers should be done, as reports showed that there was a rapid rise in the number of cases among adolescents in industry.

After a discussion Dr. Gray proposed a vote of thanks to Dr. Warin.

Through the kindness of Dr. Warin and his wife the Group were able to have tea at their house and had an opportunity to see the lock and the beautiful old church at Iffley.

An informal dinner party was held at Woodstock, to which the lecturers were invited.

The Sunday morning meeting was held at the Radcliffe Infirmary. Dr. V. Smallpeice, the consultant paediatrician, opened with a practical and informative talk on anaemia in young children. After pointing out the normal variation in haemoglobin levels in the early years, she went on to discuss the causes of departures from normal. She stressed the fact that when anaemia was found in a baby it was not sufficient treatment merely to supply iron, but that the underlying cause should be carefully sought out and treated. An iron deficiency anaemia responded, she said, as well to a simple iron mixture as to the more elaborate preparations.

Dr. Mary Coxon followed her with an illustrated lecture on retrolental fibroplasia. This cause of blindness, which occurred in small premature babies, she said, appeared to be limited to centres where the most up-to-date and efficient care was given. She outlined the development of the lesion and said that while the cause was still unknown there were several theories of its genesis. Vitamin E was being tried as a method of prevention and the relation to oxygen and relative anaemia was discussed.

Dr. Hugh Ellis then showed an interesting case of lead poisoning in a little girl and gave us a graphic description of the detection of the source of poisoning in the country inn where she lived. He discussed several similar cases of lead poisoning which had come to his notice and pointed out that the disease to-day was probably not as rare as had been thought.

Dr. Marie Clarke proposed a vote of thanks to the lecturers, which was carried with acclamation.

#### NORTH-WESTERN M. & C.W. AND S.H.S. SUB-GROUPS

President: Dr. Gladys Wilkinson (A.S.M.O., Cheshire).

Hon. Secretary: Dr. E. M. Jenkins (Sen. M.O. S.H.S., Manchester C.B.).

A meeting of the Sub-groups was held in the Public Health Committee Room, Town Hall Extension, Manchester, on Friday, January 25th, 1952, at 5 p.m. Thirteen members were present.

#### Lung Resection

The President introduced the speaker, Mr. Christopher Parish, F.R.C.S., and explained that he had kindly come along at very short notice in place of Mr. Graham Bryce, who was indisposed, to give a talk on "Resection of the Lung."

Mr. Parish then read, with interspersed comments, a long and interesting paper dealing with the story of operations on the lung from its early history to the present day. The first date of which we have records in this country was in 1499. Mr. Parish referred to many instances after that date, the results of which were far from satisfactory. There were operations in 1844 and these were recorded, but the results were doubtful. It was not

(Continued on page 178.)

## OFFICIAL NOTICES CITY OF NORWICH

APPLICATIONS for the posts of ASSISTANT SCHOOL DENTAL OFFICERS are invited from registered dental surgeons, male or female. Salary scale £800 per annum rising by annual increments of £50 to £1,250 per annum. Particulars can be obtained from the Medical Officer of Health, 68, St. Giles' Street, Norwich.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH The Annual Dinner

The annual dinner will be held on Thursday, October 23rd next, at the Piccadilly Hotel, London, W.1, at 6.45 for 7.15 p.m., with the new President (Andrew Topping, T.D., M.D., F.R.C.P., D.P.H., Dean of the London School of Hygiene and Tropical Medicine) in the chair. The principal guest will be Mr. Iain Macleod, P.C., M.P., Minister of Health.

It is hoped that there will be a large attendance of members and their guests. The charge for tickets will be 25s. each (for those paid for at the time of application up to October 16th): 27s. 6d. each where applications and/or remittances are received after October 16th. This is inclusive of gratuities but not of drinks and cigars or cigarettes. Evening dress with decorations.

Applications for tickets with remittances should be sent as early as possible to the Executive Secretary, Society of M.O.H., Tavistock House, Tavistock Square, London, W.C.1.

**Public Health** is the Official Organ of the Society of Medical Officers of Health and a suitable medium for the advertisement of official appointments vacant in the health service. Space is also available for a certain number of approved commercial advertisements. Application should be made to the Executive Secretary of the Society, at Tavistock House South, Tavistock Square, W.C.1.

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N A P T

## NEW PUBLICATIONS

### 'HOME WORK' WITH A DIFFERENCE by MURIEL OWEN-DAVIES, A.M.I.A., S.R.N.

A survey of remunerated 'Home Work' for tuberculous patients based on personal investigation.

Ten Shillings and Sixpence

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Fourteen summarised Refresher Course lectures for the guidance of Chest Physicians, Industrial Medical Officers and Welfare Workers.

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until 1891 that some success followed the resection of a diseased apex. For the 30 years following most lung operations were limited to cases of pleural empyema.

The First World War, however, reopened the scope and possibilities of chest surgery, and continuous investigation and research had been carried out subsequently, but even as late as 1936 the mortality rate of operations such as lobectomy was usually as high as 60%. One of the greatest difficulties was the question of anaesthesia, and it was only after the introduction of methods using positive pressure chambers, now used exclusively, that real success was achieved.

Mr. Parish reminded us of the particular dangers of infection, including the "spill over" to the other lung as well as brain abscesses. These complications have been lessened considerably since the introduction of the "antibiotic umbrella." Pleural infection is still troublesome, while the bronchial fistula remains a common and serious post-operative complication. Mr. Graham Bryce was the first surgeon to use the method in 1933 of insulating the pedicle after resection of the lung. This operation, under modern methods, is comparatively safe nowadays and the mortality rate is a little more than for an appendix. It is undertaken with complicated anaesthetic apparatus and may last anything from six to seven hours. More or less continuous blood transfusion may be necessary simultaneously. A normal amount needed is often 8 pints.

Throughout the lecture various points were illustrated by a most interesting and informative selection of lantern slides, although regret was expressed that Mr. Parish was unable to show the Thoracic Unit's film on this subject, because it was being used at a Medical Society meeting in a nearby borough.

A vote of thanks was then called for by Dr. Hilary Crewe, who explained that it gave her special pleasure, not only because of the very valuable and instructive paper she had heard, but because she had known Mr. Parish for a very considerable time, even in his student days when he was always one of the brightest members of the class.

A clinical meeting was held in the Neurological Department of the Manchester Royal Infirmary on Friday, February 22nd, at 5 p.m., by arrangement with Prof. Sir Geoffrey Jefferson.

The President, after a few brief remarks, introduced Dr. Liversedge, B.A., B.Sc., M.D., M.R.C.P., who gave a most interesting lecture-demonstration on a number of children suffering from various diseases of the central nervous system.

The first cases shown were of tuberculous meningitis treated by streptomycin, treatment which had to be continued for about seven months to effect a cure. For the first month it was given intrathecally and for the following six intramuscularly. Since its introduction 16 cases had been treated at the Royal Infirmary by streptomycin and 10 were still alive. Of these two became completely deaf and were taught to lip-read before losing all hearing. One was left with a slight defect, i.e., right foot drop. One case, a little girl of six, was shown who could easily write her name on the blackboard.

The second condition, cerebral palsy, was demonstrated in a girl who was now working successfully as a telephone operator. When only seven years old she first developed a right-sided tremor, two years later she had scarlet fever and the tremor condition became worse. She was first seen six years afterwards with intention tremor and was found to have a right homonymous hemianopia with slight wasting down the right side. There were signs of spasticity and the reflexes exaggerated. With these signs of involvement of the pyramidal tracts, a diagnosis of infantile hemiparesis was made. After further investigation she was found to have a cyst of the left ventricle with dilatation and hemi-atrophy of the brain. She was treated with Aramine and in spite of athetosis was well rehabilitated, although at one time she went to the Child Guidance Clinic because she became emotionally disturbed and depressed.

The third case was a girl of 28 who was first seen 10 years ago. Her history revealed fits in infancy which cleared at the age of three. Later she developed facial disfigurement and the fits recurred at 16 years of age. The disfigurement was diagnosed as athetosis abacum. A phakoma on the left retina was discovered and a diagnosis of congenital tuberous sclerosis or epiloia was made.

The fourth case shown was a boy who was brought to the O.P. department having had a fit. He had no physical signs except slight furring of the optic discs, (?) slight papilloedema.

An electric encephalogram showed focal disturbances in the parietal region of the left hemisphere (in 1944). He left the district but returned from Ireland in 1949 with a history that at times of excitement he bumped into things on the right side and exhibited certain disorders of behaviour. He was admitted for 10 weeks and the cerebro-spinal fluid pressure rose from 200 to 275, protein content from 120 to 230, and the right-sided bumping increased. He was diagnosed as having a neoplasm on the right side of the brain and a restricted field of vision on that side in the lower region. An Angiogram of the internal carotid artery showed some deviation to the right. He was still under observation.

Lastly four cases of minor epilepsy were shown, ages 13, 12, 7 and 6, all having sensations varying between 20 and 50 daily. Amongst the drugs being tried were Tridione, Fenurone and Mylontine. Two of the children showed minor manifestations during the short course of the demonstration.

A vote of thanks proposed by Dr. Maxwell Reekie, who had known Dr. Liversedge in their student days, was most heartily applauded.

### JOINT TUBERCULOSIS COUNCIL

The annual luncheon given by the J.T.C. took place this year at the National Liberal Club on May 17th, under the genial chairmanship of Dr. Peter Edwards. Dr. A. Sandison, Ministry of Pensions observer and a former T.O., proposing the toast of the Council, recalled the early days of the anti-tuberculosis service and even battles between T.O.s and M.O.s.H. He paid tribute to the influence of Dr. Ernest Ward in getting the J.T.C. set up in 1924. Dr. Edwards in reply said that in the J.T.C., like the National Liberal Club, every member had his own opinions. But the J.T.C. did represent all the interests in the anti-tuberculosis field and a valuable feature was the presence of observers from all the Central Departments concerned; these latter contributed much as well as taking away the combined views of the Council.

Prof. F. G. R. Heaf, proposing the guests, gave special welcomes to Mr. Ainsworth, of the Ministry of Health, and Dr. James Watt, a distinguished former member and chairman. He welcomed also a number of editors from the medical Press for whose aid and cooperation they were indebted. Mr. G. L. C. Elliston, Editor of *PUBLIC HEALTH*, replied for his colleagues and hoped that they would enjoy the annual hospitality of the J.T.C. on many further occasions, although the day would come when this would be a farewell banquet on the occasion of the extinction of tuberculosis. Dr. Dudley Irving (Canada) also replied.

### Unsewered Areas. A New Contribution to the Problem. (Pp. 26.) Racasan, Ltd., Ellesmere Port, Cheshire.

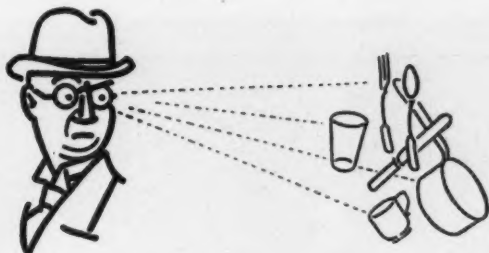
This is, frankly, a booklet published by the makers of Racasan Fluid, but the reports by medical men, engineers, sanitary inspectors and other technicians on the use of this product are convincing and do suggest that this firm have a product which can solve difficulties of sanitation in rural schools or other institutions where there is no water-carriage system, and can be recommended for use by householders or shopkeepers in these areas. The first paper is an extract from Dr. F. T. G. Leshman's presidential address to our School Health Service Group on "Rural School Sanitation," which was published in *PUBLIC HEALTH*.

### Elementary Child Care—St. John Ambulance Association. Price 1s. 4d. 1952. London.

This little book is a companion to those on Elementary First Aid and Home Nursing for the Housewife, and its aim is "to make available in simple language some of the basic principles of child care." It is well arranged and charmingly illustrated and contains some brief but sound, common-sense advice on child care. The instructions on infant feeding, however, are far behind the modern teaching that protein foods during the weaning period are needed and that a more varied diet should be given to babies under a year. It is to be hoped that this section will be brought up to date in a subsequent edition.

This should prove a useful little book as an introduction to the subject of child care.





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A solution of chloroamphenicol B. P., 10%, in propylene glycol for topical application and aural instillation.

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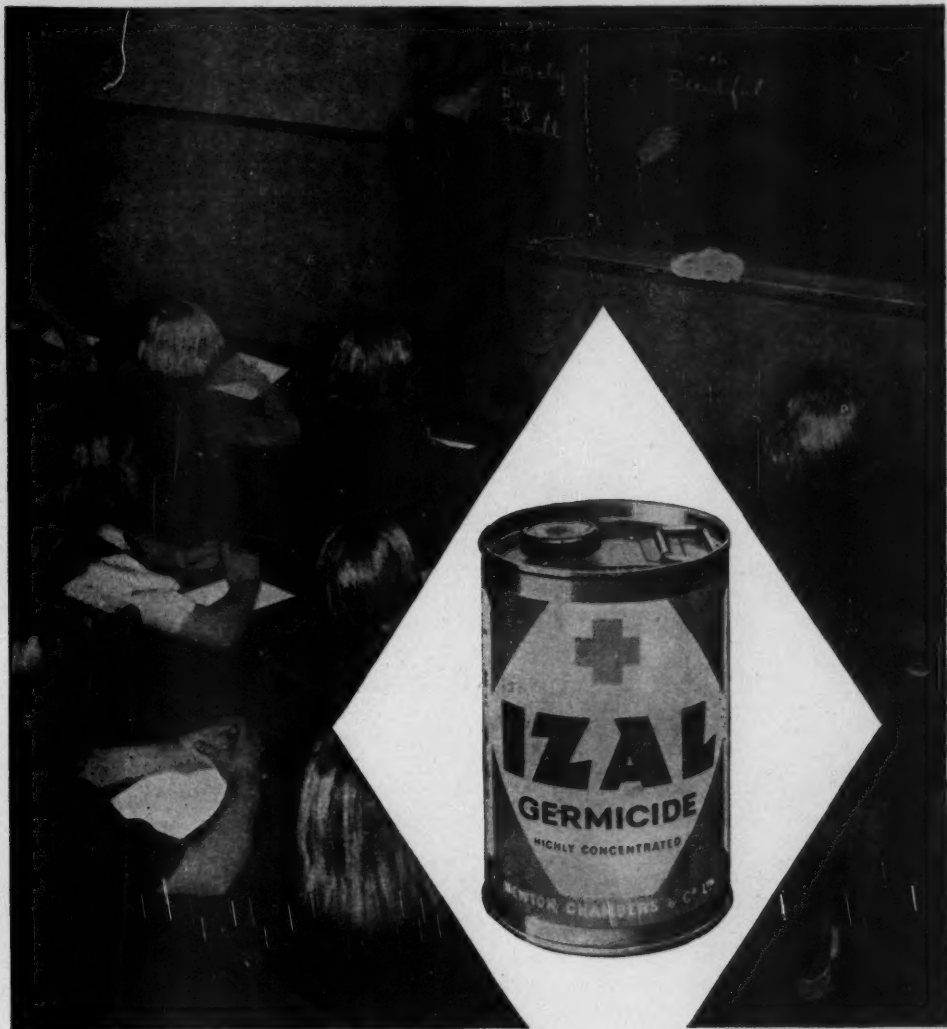
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The usual high spirits of young Americans, the usual 4th July fireworks, the usual blank cartridge and firework wounds—and next week, no doubt, the usual 95 per cent of deaths among those contracting tetanus. But no! In the year 1904, every person who received a prophylactic dose of antitetanic serum survived. Since 1904, profound advances have been made in the prophylaxis of tetanus. Due in no small part to work at The Wellcome

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*Note. 'Wellcome' Tetanus Antitoxin is now labelled in terms of the new 1930 International Unit which is twice the strength of the old (1928) unit and is therefore equal to the U.S.A. unit.*

## 'WELLCOME' TETANUS ANTITOXIN



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